Maternal and Child Health Services
Title V Block Grant

State Narrative for Alaska

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Commissioner of the Department of Health and Social Services signs the Title V application with the required Assurances and Certifications attached for reference. This information is also kept on file in the Division of Public Health, 4701 Business Park Blvd. Building J Suite 20, Anchorage, Alaska 99503-7123.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Section of Women's, Children's and Family Health (WCFH) held two stakeholders meetings on June 5th, 2007 to review the Title V MCH Block Grant application process and solicit input related to performance measures and activities. They invited members of the focus groups used during the needs assessment process of 2005, managers of key partner programs within and outside of Alaska Division of Public Health, and parents, as well as other key stakeholders. Facilities and programs that were represented include: hospitals, federally qualified health centers, infant learning, nursing education, insurance, injury prevention, chronic disease prevention, Alaska March of Dimes, Alaska Native health, private medical practice, child protection, oral health, Governor's Council on Disabilities and Special Education, and local nonprofits that address children with special needs.

Recommendations from the groups generally served to reaffirm our current activities and plans for FY2008, as well as introducing some valuable new ideas. Feedback from attendees related to the process was overwhelmingly positive with many expressing appreciation, not only for a chance to give their input, but to learn about the MCH Block Grant itself. The facilitator submitted a report summarizing recommendations. These will be incorporated into the performance measure narratives and tables of activities.

/2009/ In April 2008 we convened the first Perinatal Advisory Committee for a half-day meeting in Anchorage. Most of the major birthing facilities, as well as Medicaid, Blue Cross, consumers and the March of the Dimes, were represented. One of the goals was to set the stage for a mutually beneficial ongoing relationship with relevant data and standards of practice as the backdrop for our efforts, as well as to review the progress made on the related performance measures and gather input on challenges, opportunities and ways to collaborate to improve performance.

Priority issues identified by the attendees included the desire to work on smoking and alcohol cessation prior to pregnancy, postpartum depression early recognition and treatment, preconception care and improving the system for timely enrollment in the SCHIP program for

pregnant women.

In addition, performance measures were discussed at the related advisory committees for newborn hearing screening, newborn metabolic screening, adolescents, and oral health. These four committees meet regularly to discuss data outcomes and provide input to program designs and interventions. In addition, feedback is solicited from physicians at the annual presentations at the Anchorage and Fairbanks Pediatric/Perinatal Grand Rounds, All Alaska Pediatric Partnership committee meetings, and specific community visits. All of these activities contribute to the ongoing work of updating our needs assessment and performance priorities. //2009//

/2010/ During FY 2009 contact with stakeholders occurred through a multitude of advisory committees and task forces, most of which are mentioned in Chapter III B, Agency Capacity. In addition, WCFH is in the preliminary stages of forming an interdivisional Preceonception Care Committee. Staff met 4 times in 2009 to develop goals and objectives, strategies, activities and stakeholder participants. Youth were surveyed through a community assessment process on their views of health priorities and reaction to our activities related to injury, suicide and teen pregnancy prevention. Families were included in the MCH Block grant review process this year through the beginning formation of a Family Advisory Committee. National performance measures #2-6 and those state performance measures and the planned activities for the following SFY related to CYSHCN were reviewed with families on the advisory committee. We received a number of rich ideas and much feedback regarding issues and concerns about systems and services across the state. These comments have been incorporated into work plans and activities in the coming fiscal year.

It is anticipated that the year-long conversations with our stakeholders will be the jumping off point for the stakeholder meetings this Fall for the 2010 Needs Assessment planning process. For the FY 2010 Block Grant reporting process, program managers were asked to assess agency capacity and program strengths and weaknesses relating to national and state priorities. //2010//

A public notice informing the general public that Alaska's Title V MCH Block Grant application is available for review was posted on the state's on-line public health notice system on July 8, 2009. In addition, members of the stakeholders groups were notified of the applications' availability for review. In past little to no feedback has been received from this public posting. As a result, this year, program managers specifically addressed national or state performance measures related to their programs as well as planned activities during advisory committee meetings and work session.This input was integrated into planned activities for the coming year.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

A meeting was held on June 5, 2007 for Title V MCH Block Grant stakeholders, sponsored by the Department of Health and Social Services, Division of Public Health, Section of Women's Children's and Family Health (WCFH). The purpose of the meeting was threefold:

- to review the state's progress on national and state performance measures
- to either reconfirm or suggest different state priorities from those developed during the initial Needs Assessment
- to develop ideas for new activities and partnerships

Invited stakeholders represented public and private health care institutions that serve women and children. A list of the agencies is included.

The meeting was organized in two sessions. The morning session focused on perinatal and women's health issues and the afternoon session focused on children and children with special health care needs. For both sessions, Stephanie Birch, Title V Director and WCFH Section Chief, gave an overview of the Title V program and planning process. WCFH staff then presented trend data, past year's activities and current year's activities for each of the national and state performance measures highlighted during the session. (See Slides 1 and 2 in the attachment).

The attendees were divided into small discussion groups and given an assigned set of performance measures to discuss with respect to the following questions:

- Which performance measures do you see as the highest priorities? (Pick top 3)
- Are the FY 07 & 08 activities appropriate? What others should be included?
- What other partners might help achieve the MCH performance measures? Think in terms of both leveraging resources and non-traditional partners.

Each subgroup presented a synopsis of their discussion and suggestions to the entire group. The following national and state performance measures were chosen as a top priority by the group that took it under consideration:

- National Performance Measures # 2, 4, 5, 8, 10, 13, 15, 16, 17, 18
- State Performance Measures # 1, 4, 5

Ideas for new activities and partnerships developed within the subgroups were shared with the overall group.

A draft summary of the meeting is attached.

//2009// The WCFH Perinatal Advisory Committee was established and convened for the first time in April 2008. Attending were 32 health care providers from across Alaska, representing a variety of geographic areas, types of facilities, and health care professions. The purpose of the committee is the establishment a network for communication between parties about important perinatal issues, including priorities, concerns, best practices, data, and other research, the overarching goal being to improve perinatal outcomes. All of the performance measures and current data related to perinatal health were reviewed and discussed. Priority areas were

identified for the year based on the data and the status of outcomes. Plans for the Perinatal Advisory Committee are to meet 3 times a year. The most frequent input was participants wanting to learn more about CenteringPregnancy and CenteringParenting as means to provided focused education in an manner of presentation that has evidence of effectiveness. A presentation will be arranged for our next meeting in September, with the hope of garnering adequate interest and commitment to hold a 3-day workshop to implement a number of Centering programs in Alaska. A draft of the summary is attached.

In addition, advisory committees for adolescent health, family planning, newborn hearing screening, newborn metabolic screening and children with neurodevelopmental disabilities also reviewed the related performance measures to assure program activities aligned with performance targets. Additional work will be done in collaboration with the Section of Chronic Disease in the areas of smoking cessation, nutrition, obesity and school health in the coming fiscal year. //2009//

/2010/ WCFH created an internal leadership team of program managers to manage the needs assessment process, headed by an MCH-Epidemiologist who also has graduate degree in Planning. The team met four times to discuss strategies for capacity assessment and to determine the role of stakeholders. Feedback from the 2005 stakeholder meeting participants indicated that the review materials (all 43 WCFH Fact Sheets) were too much to absorb, although the information was excellent. We decided to further synthesize the material by providing narratives for each MCH population that blends quantitative and qualitative data with added emphasis on capacity assessment. For the 2010 Block Grant, we asked program managers to provide additional information: a) strengths and weaknesses of your core public health services (organized by the four pyramid layers); and b) the most critical unmet need or service gap in your program. In areas where additional capacity assessment data is needed, we will conduct key informant phone interviews with resource people. Four MCH-Epi staff took the year-long CDC teleconference course on Needs Assessment. We plan to complete the assessment process by January 2010.

The state hass added H1N1 as a state priority. This has been operationalized primarily through the disaster planning process. In addition, the School Nurse consultant is working with the schools on immunization plans. //2010//

III. State Overview

A. Overview

Alaska's health care system differs from most other states in that there are virtually no local health departments that function under the umbrella agency of the state health department. Two communities have locally organized health departments -- Anchorage and the North Slope Borough. In addition to these two local health departments, the entities operating in Alaska to deliver health care services include: the Department of Health and Social Services; private physicians and other health care providers; private hospitals; federally funded hospitals (military and Native); non-profit federally funded community health centers; and Native health corporations. Coordination of service delivery and systems development is an ongoing effort within the state among these entities.

In March 2003, the Department of Health and Social Services (DHHS) underwent a major reorganization that resulted in internal consolidations, name and function changes for four divisions, and the transfer of partner programs into the DHSS from other state departments. In part, the reorganization restructured the way Alaska uses Medicaid funding for programs and maximizes federal funding for state services.

The reorganization meant significant changes for MCH programs. In July 2003, the Section of Maternal, Child and Family Health (MCFH) within the Division of Public Health, the agency that administered Title V funds, was dissolved and specific programs and services within MCFH were reassigned to new or existing Divisions within DHSS. Programs formerly consolidated under MCFH that were moved to new or different divisions were: Adolescent Health (coordinator position eliminated); Children's Initiatives/Special Projects; Healthy Families Alaska; Infant Learning/Early Intervention Program; WIC/Nutrition Programs; Community and Family Nutrition; Breast and Cervical Cancer Screening; Oral Health; EPSDT; Family Planning; Genetic Screening; Newborn Metabolic Screening; Newborn Hearing Screening; Specialty Clinics; Women's Comprehensive Health Care Initiative; Denali KidCare Outreach (outreach positions eliminated in 2003); Children's Behavioral Health (coordinator position eliminated in 2003); MCH-Epi; and the Family Violence and Prevention Project. The Division of Health Care Services (formerly the Division of Medical Assistance) became the agency to administer Title V funds.

The appointment of a new Director of Public Health in June 2004, Dr. Richard Mandsager, has helped to revitalize the focus of public health and to look for opportunities to utilize the principles of quality improvement in shaping the role of public health. Dr. Mandsager had been an active participant in a variety of MCH projects and committees prior to his appointment. One of his goals in joining the administration was to reformulate an MCH section and evaluate what made the most sense in terms of transferring programs back to the Division of Public Health. The Section of Women's, Children's, and Family Health (WCFH) was created and a new section chief (Title V/CSHCN Director) was appointed.

As of July 1, 2005, some MCH programs administered by the Division of Health Care Services were transferred to the new WCFH section including Newborn Metabolic Screening, Newborn Hearing Screening (EHDI), Specialty Clinics, Birth Defects and Genetics Clinics, Oral Health for Children and Adults, Family Planning, and the Breast and Cervical Cancer program. Also transferred to WCFH were the Abstinence Grant administration from the Office of Children's Services and the MCH Epidemiology program from the Section of Epidemiology.

Former MCH programs that remained outside the Division of Public Health, despite a request to the Department's Commissioner, include WIC, Early Intervention/Infant Learning program, Healthy Families Intensive Home Visitation program, Community Nutrition and the 5-A-Day program and the Early Comprehensive Care Systems grant. These continue to be located in the Office of Children's Services. A close working relationship has been maintained between the Title V/CSCHN Director and the managers of the Early Intervention grant and the ECCS grant.

Since October of 2004, the Section Chief of Women's, Children's and Family Health (WCFH) and Title V/CSHCN Director has had a dual reporting relationship between the Division of Health Care Services and the Division of Public Health. In July 2005, the reporting relationship changed to the Division of Public Health. However, the Title V/CSHCN Director continues to work closely with the Division of Health Care Services. This enables her to offer public health policy considerations and information regarding potential outcomes when Medicaid policy was being considered. In addition, she has continues to work on regulation changes for current and new Medicaid programs including home health (regulations affecting payment methodology and streamlining processes for pregnant women and children to be considered eligible for home health care services); school based services including PT, OT, speech and language and audiology services for Medicaid eligible children; Durable Medical Equipment regulations including audiology equipment of deaf and hard of hearing children and newborn/infants with Cleft Lip/Palate disorders; and travel policies affecting CSHCN. As she is the only master's prepared nurse (with experience in perinatal, neonatal and pediatric nursing) in Medicaid, her expertise regarding clinical issues is requested on a regular basis. Finally, she is leading a special quality improvement project in collaboration with her colleagues in Medicaid and the Medicaid waiver program to improve the discharge planning and placement process for medically fragile children discharged from the state's only Level III and tribal Level II NICUs, both of which are located in Anchorage. In summary, the work conducted in collaboration with Medicaid has provided a new pathway to working toward resolving health access issues, racial disparities, and improved an understanding of tribal health delivery and its relationship to the federal Medicaid system of payment.

//2008// Dr. Jay Butler was named the new director of public was named in October of 2007 with the departure of Dr. Richard Mandsager. Dr. Jay Butler M.D. had been in the role of Deputy Director of Science and Epidemiology. A CDC epidemiologist, Dr. Butler has been assigned to the Alaska CDC center for several years and as part of his assignment joined the Division of Public Health. His background is rich in pediatrics, internal medicine, and epidemiology and he has brought a wealth of experience in pandemic flu preparation and arctic investigations.

Attempts to move Women, Infant and Child Nutrition from the Office of Children's Services (child protection) were not supported by the Assistant Commissioner of Finance and the program was instead moved to the Division of Public Assistance to assist with outreach and the banking/voucher processes. Other proposed changes to pull back on former MCH programs will be discussed later in the document //2008//.

/2009/ In August of 2007, Beverly Wooley was named Director of Public Health. Ms. Wooley previously held the positions of Anchorage's Director of Health and Human Services and Manager of the Division of Community Services in Anchorage where she managed the WIC program, maternal-child health, immunizations and several other public health programs. Beverly got her start in public health as a registered dietician in the WIC program located in the states northernmost village, Barrow, Alaska. Dr. Jay Butler was named to a deputy commissioner level as Chief Medical Officer. The Division of Public Health reports directly to him. In May, 2008, Bill Hogan was named Acting Commissioner of the Alaska Department of Health and Social Services, following the resignation of Karleen Jackson. //2009//

/2010/ Acting Commissioner, William (Bill) Hogan was named Commissioner in mid year 2009. In June of 2009, Beverly Wooley, Director of Public Health was asked to step down by the Governor of Alaska. In addition, Dr. Jay Butler step down as of June 19th to take a CDC assignment to work on influenza planning. As of this writing, no replacements have been named by the Governor. Additional work has been done with the Office of Children's Services in collaboration with the Early Comprehensive Care Systems in grant through the development of an Intradepartmental Coordinating Council for Early Care and Learning. Staff from WCFH has also initiated collaborative work between other sections within the Division of Public Health. These efforts include work on injury prevention and surveillance

as well as coordination of data collection for the child death review team with the Section of Injury Prevention and EMS. Work in the area of asthma, smoking cessation for pregnant women, diabetes in women and healthy weights for children, pregnant women and women across the lifespan are underway with the Section of Chronic Disease. Finally an interdivisional effort is underway to address pre-conception health.//2010//

Principle Characteristics of the State of Alaska

Two defining characteristics of the state are physical geography and the racial diversity of the population. Alaska is a large, sparsely populated state. The land mass of the state encompasses 571,951 square miles, averaging a population density of just 1.1 persons per square mile. This is the lowest population density of any state.

Approximately 75% of Alaskan communities, including the state's capital city of Juneau, are not connected to the road system. Accessing "nearby health services" or specialized health care means travel by commercial jet, small plane, the state marine ferry system, all terrain vehicles, small boats or snow machines. Some residents may travel distances equivalent to traveling from Washington, D.C. to New Orleans for even routine medical care. Moreover, severe weather can render travel impossible, creating especially critical situations in medical emergencies.

The geographic isolation of rural communities means significant challenges in assuring all MCH populations have access to routine preventive care, acute medical and specialty care. Specialty care, even in urban areas of the state, is limited. For example, the only Level III neonatal intensive care facility is located in Anchorage. Many communities have no facilities equipped for childbirth so pregnant women must leave their homes two weeks before their due date. Even well-child check-ups, prenatal exams and regular dental exams are difficult to provide. Recruiting and retaining physicians and primary health care providers for non-urban practices is also a barrier to providing health care services.

The 2004 population estimate is 681,507 of which 69.3% is reported as Caucasian only. The largest racial minority is composed of Alaska Native/American Indian (alone or mixed race), comprising 18.5% of the population. Other significant ethnic groups (reported alone or in combination) are Asian, 5.2%, African American, 4.2%, Pacific Islander, 0.8%, and Hispanic/Latino 3.8%.

Of the people who dwell in rural areas, 82% are Alaska Natives. However, there is a trend of people moving from rural villages to regional centers and urban areas of the state. Looking at it another way, in 2000 58% of the statewide native population lived in rural areas and 42.3% lived in five Urban Census Areas: the Municipality of Anchorage, the Matanuska-Susitna Borough, the Kenai Peninsula Borough, the Fairbanks North Star Borough and the City and Borough of Juneau. In other words, Alaska Natives made up 10.4% of the total urban population, double that of 1970 (part of the increase may be due to the fact that in the 2000 Census people were able to identify themselves as Natives of mixed race). It is predicted that the native population will be increasingly urban. More than half of all Alaska Natives may live in urban areas by 2020.

Alaska is a fairly young state, where in 2000 the median age was 32.4 years compared to 35.3 years for the entire United States. Alaska Natives are even younger, on average than the state as a whole (25.8 years). Residents age 65 or older comprised only 5.7% of the population of Alaska compared to 12.4% for the U.S. population.

Disparities

The largest differences in health trends status are between the native and non-native populations and between rural and urban populations. They are related in that the majority of people living in rural areas are Alaska Native people. Four years ago, WCFH (formerly MCFH) facilitated a process for Region X states (Oregon, Washington, Idaho and Alaska) to look critically at health

disparities between urban and non-urban populations. Using existing population and MCH health data, information about health care delivery systems and geographical characteristics; states were able to build a detailed picture of their MCH populations, their health status and barriers to accessing health services.

Significant improvements in the health status of natives have been made since the 1970s as a result of investments in village sanitation, housing, and access to health care services and facilities. For example, nearly 90 rural communities received new sanitation facilities between 1975 and 2003. And by 2003 health clinics staffed by local health aides were established in approximately 170 villages, up from two or three in 1974, as well as several new health centers in regional centers in western, southwestern and interior Alaska. As a result, infant mortality and rates of infectious disease declined dramatically. Nevertheless, as of 2003, 32 communities in interior and western Alaska still lacked public sanitation systems. In 23 other communities less than 30% of households had a link to the public sanitation system. Many rural residents say clinic facilities need improvement.

Nevertheless, the research effort documented continuing disparities in Alaska between urban and non-urban populations and that Alaska Natives are at higher risk for a number of health issues. For example, the average rates for childhood mortality, teen pregnancy, fertility, mothers reporting smoking and drinking are significantly higher for those living in frontier and remote areas. The rates also indicate that fewer women in frontier and remote areas received early and adequate prenatal care.

Alaska Natives have higher rates of infant deaths among children (age 1 - 19 years), lower rates of prenatal care, higher rates of smoking during pregnancy, teen births and suicide mortality. As Natives become increasingly urban or adopt western lifestyles and diet, either by choice or not, chronic diseases such as diabetes, and heart disease are of increasing concern.

Even if ideal health care systems were in place, socio/economic factors create additional barriers for populations living in frontier and remote areas. Compared to urban populations, frontier and remote populations are poorer, lack health insurance, have limited employment opportunities and face cultural or language barriers. Poverty is correlated with many of the health status and access disparities for non-urban populations. Higher unemployment, lower wage jobs and seasonal industries all contribute to the high poverty and near-poverty levels for non-urban populations. Uninsured populations are less likely to access routine, preventive care and more likely to seek care when health problems are severe and require treatment. Lack of preventive health care is a major contributor to poor health status for MCH populations.

A culturally diverse workforce that reflects the culture, language and respects the traditions of the populations is a crucial strategy for reducing health disparities. While the state has made progress creating an infrastructure to train and recruit a culturally diverse workforce, many Alaska Natives face cultural barriers when accessing health care. WFCH supports local expertise and culturally competent care in the provision of MCH services through the training and development of parent paraprofessionals to assist parents of newly diagnosed children to navigate the system of care.

Finally, one area that requires a significant investment of resources is the range of behavioral health issues that impact MCH populations in the state. Alaska ranks among the top ten states in suicide rates for 2002, almost twice the national rate. Mental health disorders, stressful life events and substance abuse are risk factors for suicide. Children are significantly impacted by alcohol and drug abuse, especially if their mothers are abusing. A majority of families in Alaska in the child protection system have problems with alcohol or drugs. The state has recognized and responded to significant behavioral health issues facing older populations and adolescents. Recently the state has also recognized that younger populations including infants and toddlers are a population that can and does have behavioral health needs.

/2008/ In FY 2007, WCFH started a survey of women who had a live birth in 2004 and who participated in the Alaska Pregnancy Risk Assessment Monitoring System (PRAMS). The data collected from the survey will allow us to assess toddler health for the first time. Simple analysis of the data has already begun. //2008//

/2009/ The toddler survey, Alaska Childhood Understanding Behaviors Survey (CUBS), is currently in its second phase. Phase I was a two-year follow-up of PRAMS survey respondents while Phase II is a three-year follow-up. To date, CUBS response rate has been 50% or better. Analysis on Phase I weighted data is underway. Analysis on Phase II will start after one full year of data has been received. //2009//

/2010/ Teen birth rates in Alaska continue to vary greatly by region. Rates in some rural areas of the state are more than two times higher than in some urban areas. To address this issue, WCFH has partnered with the Division of Public Assistance to reduce the number of teen and out of wedlock births in the three regions of the state with the highest teen birth rates. The Adolescent Health Program is working closely with the Alaska Network on Domestic Violence and Sexual Assault to address the link between dating violence and teen sexual risk behavior in areas of the state that have high rates of both violence and teen births, in the hopes of decreasing the disparities between rural and urban census areas.

An analysis published in March 2009 (published online in April 2008) in the Maternal and Child Health Journal indicated that the elevated risk of postneonatal mortality among Alaska Natives in Alaska was associated with higher rates among this population of low maternal education, prenatal tobacco or alcohol use, and unmarried women with no father's name indicated on the child's birth certificate. During 2007-2009, the results of this analysis was shared in multiple venues, including to the Primary Care Council, at the Council of State and Territorial Epidemiologists national conference, at the national Maternal and Child Health Epidemiology conference, and at Pediatric Grand Rounds. (Article available at http://www.epi.hss.state.ak.us/mchepi/pubs/misc/MaternalRiskFactors_2008.pdf)

Rates of unintentional injury among adolescents and teens are higher in Alaska than the nation, and higher among Alaska Native adolescents and teens than non-Natives. The MCH program was represented by MCH-Epidemiology staff at the Keeping Kids Alive conference in May 2009. The conference brought together state leaders in maternal and child health, injury prevention, and child death review, as well as national partners, to enhance state capacity to develop, manage and sustain effective prevention-focused CDR programs, to improve the connections between state Child Death Review (CDR), injury prevention, and MCH programs, and to build bridges between key national organizations and state partners. an action plan was developed in partnership with the Alaska Injury Prevention Director to implement some of the lessons learned from this conference over the next six months. A representative from the injury prevention program has been invited to serve on the CDR committee. The Injury Prevention Director hopes to start participating in quarterly phone conference discussions with the MCH Director and other decision-makers about CDR findings and how recommendations can be implemented.

For the past year, the Title V MCH/CSHCN Director has actively participated as the senior staff member representing the Division of Public Health on the Commissioners State Child Policy Team. This team also includes division directors and leadership staff from juvenile justice, behavioral health, public assistance and the commissioner's office. They are tasked with formulating and evaluating policies and regulations that most effect children. Work by the team includes a "Bring the Kids Home" initiative centered on developing a community based behavioral health infrastructure in local communities to support children with social emotional disorders needing residential or post psychiatric hospitalization services; improvement in case management of families; development of a

positive behavioral support program for school age children with significant behavioral problems; support in systems development for children with autism and other neurodevelopmental behaviors; work on resolving confidentiality issues between divisions that currently limit information sharing and affect effective service delivery.

Finally, staff from WCFH and the MCH/CSHCN director are involved in a needs assessment process and comprehensive planning focused on transition issues for adolescents to adults with a special focus on children with disabilities, behavioral issues, as well as those in foster care. //2010//

Current State Priorities and Title V Programs

The Department of Health and Social Services has developed the following goals and strategies for FY04-FY06Goal #1: Establish fiscal stability to DHSS programs through federal fund maximization, prudent cost containment, and streamlined business processes. Reduce dependence on new state general funds through the following: replace $20 million in state dollars with federal Medicaid dollars in FY04 by implementing agreements between hospitals and state-funded community programs; offset $5 million in state dollars in FY04 with federal Medicaid dollars by investment in Alaska Native tribal health services infrastructure through cooperative agreements with the state, private health care providers, local communities and tribal programs; review business process and eliminate inefficiencies and redundancies; conduct program reviews of all DHSS programs to find options for offsetting state funds with federal funds; carry out aggressive federal agenda to lock in fair treatment of Alaska in funding formulas and policies across a diversity of federal programs; implement cost containment options to the extent feasible without disruption to essential services.

Goal #2: Expand access to cost effective quality services in underserved areas of Alaska through the following: carry out aggressive health and social services workforce development agenda in collaboration with the University, tribal health system, provider and employer organizations, and other stakeholder groups; develop integrated health services programs utilizing partnerships with the tribal health systems, the Denali Commission, the Alaska Mental Health Trust Authority, and other stakeholder groups; implement reimbursement for telehealth services; support the increased use of well-trained local residents in the delivery of a range of frontline prevention and treatment services under tribal health program auspice, for maximum federal fund benefit through Medicaid; develop juvenile substance abuse treatment capacity in rural Alaska.

Goal #3: Protect children and the public from negative effects of alcohol and substance abuse; reduce impact of illness and injury and promote self sufficiency for all Alaskans through the following: establish Performance Improvement Plan (PIP) for child protection system (DFYS); maximize available resources to assure completion of the API replacement project; to assure juvenile offenders are held accountable; to open Kenai Youth Facility promptly; to renovate Nome Youth Facility; and to achieve expedited compliance with court directed treatment and tobacco enforcement policy; develop in-state capacity for provision of appropriate behavioral health services to children and youth, utilizing financing arrangement that assures best use of federal funds whenever feasible; maximize federal resources to support environmental health, disease control, injury prevention, and Homeland Security programs in Alaska; strengthen home and community based services programs and self-sufficiency programs to achieve improvements in quality and cost effectiveness.
/2009/ goals: The acting commissioner of health recently published the 5 "Big Picture Priorities for DHSS for state fiscal year 2009. The overriding theme for future direction of the department is helping individuals and families create safe and healthy communities. The priorities outlined below span the breadth of the department and encompass the unique service-areas represented within. They include: Substance Abuse-Substance abuse affects every family and community in Alaska. It is a contributing factor in suicides, crime, unemployment, domestic violence, child abuse, school dropouts, juvenile delinquency, etc. We need to prevent, intervene early, treat and help people recover from substance abuse through public/private partnerships and long-term

strategies; Health and Wellness-Many Alaskans lead less happy and less productive lives, and many die prematurely each year, because of disability and death caused by tobacco, alcohol abuse, injuries, obesity, diabetes, cancer, heart disease and sexually transmitted diseases. Most of this is attributable to personal choice involving diet, physical activity and tobacco use -- and is preventable. We can do a better job of screening, diagnosing and treating these conditions; Health Care Reform-Alaska's health care system continues to be fragmented and uncoordinated and doesn't produce the kinds of outcomes we expect. By strategically focusing on care management, reforming Medicaid, creating a Health Care Commission and growing our health-care workforce, we can transform our health-care system; Long-Term Care-Seniors represent the fastest growing population in Alaska and it is our responsibility to determine what kinds of services we want for our aging parents (and grandparents) in order to keep them at home in their own communities. We need to develop a long-term care plan, improve services to those with Alzheimer's Disease and related disorders, and promote the expansion of aging and disability resource centers; Vulnerable Alaskans-We need to ensure that both kids and communities are safe, that developmentally disabled kids and adults have access to quality services and supports, and that individuals and families get the kind of financial and vocational supports they need to be contributing members of society. By focusing on family-centered services and through the use of performance-based standards and funding, we can better meet the needs of our most vulnerable citizens and their families. The Title V/CSHCN program will work to integrates its goals into the department's to assure continuity of services and meet our performance objectives. //2009//
/2010/ The goals described above remained in place for the this state fiscal year. The commissioner is currently involved in forming a stakeholder group to evaluate and update the above goals. It is unclear as of this writing who will represent the Division of Public Health in the update process. The department was successful in securing additional funding this year for some of the stated goals. General Fund increments were specifically awarded to the Section of WCFH for the Alaska Birth Defects/FAS registry, autism expansion services, and professional workforce development on caring for children with autism.
The MCH-Epidemiology has applied for a five-year competitive CDC grant to establish an asthma surveillance program. Objectives of the proposed program are: an annual asthma report; analysis of BRFSS data; and establishing data linkages or new data sources from Vital Statistics, Medicaid, PRAMS, CUBS (toddler survey), Anchorage School District, private insurance carriers, and the hospital discharge database. The grant would also be used by the Section of Chronic Disease and Prevention for intervention programs. Grant awards will be announced in August 2009. //2010//
The Process to Determine Alaska's MCH Priorities:

Alaska's State-Wide Title V Needs Assessment was completed in July 2005 by the Section of Women's, Children's, and Family Health (WCFH). The process of consisted of four phases completed over five months:
• Phase I consisted of topic selection and data gathering and analyses. Forty-three Fact Sheets were written on issues drawn from four focus areas: Pregnant Women and Infants, Children and Adolescents, Children with Special Health Care Needs, and Women's Health. Topics were initially selected by WCHF staff and an independent consultant and reflected those which were most critical, those that were aligned with national and current state performance measures, Healthy People Objectives, and those that were the propriety of WCFH. The fact sheets included three sections: Seriousness, Interventions and Recommendations, and Capacity. Information presented in these sections was later used in a survey to rank issues and assist in selecting priorities.
• Phase II of the prioritization process consisted of design, development, and analysis of a survey given to MCH stakeholders. A modified Hanlon-Pickett method to rank issues and integrated this into the survey design. Focus group participants were asked to read the fact sheets and answer a corresponding on-line survey for each issue.
• Phase III covered four half-day focus group meetings. Potential state performance measures and state priorities were identified. The State contracted a facilitator to lead and moderate discussions during the meetings. Survey results were presented to the groups at this time.

• Phase IV involved several meetings with the WCFH Section Chief and staff from the MCH Epidemiology Unit. The MCH Epidemiology Unit plays a critical role in the data coordination efforts for the Title V Block Grant Application, as well as being the entity at the State level that monitors and analyzes MCH data and emerging issues. Several of the data sources that are necessary for the state performance measures are directly from programs in the MCH Epidemiology Unit (i.e., PRAMS, Alaska Birth Defects Registry/FAS, Maternal Infant Mortality Review/Child Death Review, etc) and participation of those program managers were critical in defining the final version of the state priority needs and state performance measures. Also, this is the only unit within Public Health that has the capacity, expertise and ability to understand and critically evaluate and analyze MCH data, data sources, and potential data source issues.

The State intends the Needs Assessment process to be on-going throughout the five-year cycle. The structure is in place to produce yearly updates to the WCFH Fact Sheets that will be shared with the stakeholders from this process, State staff, and made widely available to the public/private health community. The MCH Epidemiology Unit within WCFH produces an annual Alaska MCH Data Book that is widely distributed throughout the State. The December 2005 edition, focused on Alaska PRAMS data.

Meetings with stakeholders will be on-going throughout the five-year cycle, with at least one meeting per year to distribute fact sheets, discuss progress on the State priorities and activities, and any current and emerging issues that may impact the State's capacity to address identified issues.

//2008// A subsequent edition, focusing on data from the Alaska Birth Defects Registry, was published late in 2006. This was the first comprehensive presentation of data on birth defects ever published. A second edition of the original MCH Indicators Data Book wll be completed in SFY08. //2008//

/2009/ Publication of the second edition of the MCH Indicators Data Book was delayed and will now be published in Fall 2008. Fact sheets developed as part of the 2005 needs assessment are currently being updated and are utilized extensively in education the public, consumer groups and the legislature on the health status and outcome data of women, children, children with special health needs, pregnant and postpartum women and infants. Other special analyses have been conducted and published by the MCH Epidemiology staff. A list of publications are attached as part of the block grant submission. In addition, the MCH epidemiology unit was successful in recruiting a CDC CSTE fellow to conduct surveillance studies looking at health disparities of women delivering preterm and low birth weight babies. In addition, the unit was successful in attracting a CDC Public Health Preventative Health Specialist who will be working to establish a new surveillance system looking at risk factors associated with child abuse. //2009//

/2010/ The MCH Indicators Data Book was published on the web and in print in Spring 2009 (available at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/2008.htm). Much of the data is stratified by Alaska Native status and by geographic region to illustrate disparities in key health indicators. The CDC Public Health Prevention Specialist was assigned to create the Alaska Surveillance of Child Abuse and Neglect (SCAN) Program, housed in the Maternal-Child Health Epidemiology Unit within WCFH. Alaska SCAN will serve as the central source for standardized child maltreatment-related morbidity and mortality data. SCAN uses the Centers for Disease Control and Prevention (CDC) standardized case definitions to increase the sensitivity of the system and increase nationwide comparability. SCAN program staff will partner with multiple agencies to determine their data needs and identify areas for focused data collection, providing information that will improve child maltreatment services and related interagency communications. A summary of SCAN is available at http://www.epi.hss.state.ak.us/bulletins/docs/b2008_06.pdf. These sources of data will be used during the Needs Assessment process. //2010//

in updates on work done by CSTE and PHPS and the newest MCH data book OK

//2008// Community stakeholders, many of who previously participated in the 5-year needs assessment, were invited to half day sessions to review and comment on the most recent outcome data related to the Title V MCH national and state performance measures and related past and future activities supporting the performance measures. One half-day session focused on perinatal and women's health measures and a second half- day session focused on child and adolescent health and children with special health care measures. Facilitated smaller group discussions produced additional focus areas for WCFH staff to concentrate on over the coming year. The participants were very engaged and enthusiastic about the work done to date and produced a number of ideas and suggestions for partners for future work. Many of the participants agreed to join the MCH advisory council, which will kick off in the fall of 2007. Subcommittees for children and youth with special health care needs will be formed, as recommended by the participants. The MCH council will act in an advisory capacity and assist in guiding the work done by WCFH staff. //2008//

//2009// The WCFH Perinatal Advisory Committee was established and convened for the first time, the purpose of the committee is to have a means of communication between parties about important perinatal issues, including priorities, concerns, best practices, data, and other research for the purpose of improving perinatal outcomes. In addition, the committee provided valuable input into assuring that the areas we are focusing on are of importance to them and a priority measures. This is part of the ongoing process to update our needs assessment on an annual basis. Overall, response was enthusiastic and about 45 committee members were secured. Attending were 32 health care providers from across Alaska, representing a variety of geographic areas, types of facilities, and health care professions.

In April 2008 we first convened the first Perinatal Advisory Committee for a half-day meeting in Anchorage. The primary goal of this meeting was to set the stage for a mutually beneficial ongoing relationship with relevant data and standards of practice as the backdrop for our efforts.

The strategy to initiate this conversation in the context of the group was to help participants identify 'low-hanging fruit' or obvious and doable interventions in their communities or statewide and support their data and programmatic needs. After a large group presentation of background information, the group was broken into 3 smaller groups to discuss opportunities for action, data needed to proceed, and concrete first steps they would take when returning to their work. In the process of addressing the questions posed participants unearthed a rich abundance of ideas for current and future consideration. Priority issues identified by the attendees including the desire to work on smoking and alcohol cessation prior to pregnancy, postpartum depression early recognition and treatment, preconception care and improving the system for timely enrollment in the SCHIP program for pregnant women.

Plans for the Perinatal Advisory Committee are to meet 3 times a year. Members may decide to form subcommittees to focus efforts on more narrow issues and these may meet more frequently. A recurrent request was to learn more about CenteringPregnancy and CenteringParenting and a presentation will be arranged for our next meeting in September, with the hope of garnering adequate interest and commitment to hold a 3-day workshop to implement a number of Centering programs in Alaska.

In addition, performance measures are reviewed and discussed at the related advisory committees for newborn hearing screening, newborn metabolic screening, adolescents, and oral health. These four committees meet regularly to discuss data outcomes and provide input into program designs in and interventions. In addition, ongoing feedback is solicited from physicians at the annual presentations provided at the Anchorage and Fairbanks Pediatric/Perinatal Grand Rounds, All Alaska Pediatric Partnership committee meetings, and specific community visits. All of these activities contribute to the ongoing work on updating our needs assessment and

performance priorities. //2009//

/2010/ During this fiscal year two additional advisory committees were added to WCFH. The Title V/CSHCN program was awarded one of 6 grants in the U.S. to expand services and systems for children identified with autism. This grant necessitated the development of a steering committee as well as a two additional sub-committees, all of which include parents of children with autism and service providers from across the state. In addition, a family advisory committee is in development and will be meeting for the first time in June 2009 for training on the performance measures and the process to conduct an internal review of the state's MCH Block grant application. Both new committees provide for input on performance measures related to the populations in which they represent as well on priorities of the Section of Women's, Children's, and Family Health. //2010//

Consideration of needs, priorities and competing factors can also occur at specially convened workshops. For example, in May 2006 representatives of several DHHS divisions and tribal health organizations gathered to consider how to maximize the EPSDT program to improve health outcomes of children, targeting the early childhood years of 0 -- 3. The facilitated workshop resulted in a prioritized list of strategies to pursue. The workshop was conducted by Kay Johnson Consultants and was supported by a HRSA -- MCH supported technical assistance grant.

/2009/ The work discussed in preceding paragraph was helpful in the development of the Early Comprehensive Care Systems Grant (ECCS) and the collaboration around piloting a system of continuous developmental screening as part of the ABCD Screening Academy project. In addition, work is in progress in collaboration with the Division of Behavioral Health, the Divisions of Children's Services, and the University of Alaska to develop early behavioral health intervention training and curriculum and programs in collaboration with the Early Intervention/Infant Learning programs. //2009//

/2010/ Preparation for the 2010 Title V Needs has begun. Four staff members attended needs assessment training offered by AMCHP. Four MCH-Epidemiology Unit staff members are currently participating in a year-long needs assessment course offered by Deborah Rosenberg (sponsored by CDC). WCFH Facts sheets are being updated and one-page summaries are being prepared for upcoming stakeholder meetings in Fall 2009. //2010//

Legislation

Several pieces of legislation impacting MCH populations were passed in FY 2006. A significant achievement was the passage of HB 109 relating to newborn hearing screening. This legislation requires all newborns be provided with hearing screening within 30 days of their birth, and that those identified with a positive screen or high risk factors receive a second screen or diagnostic work-up, are enrolled in early intervention and receive treatment as needed. The program requires a reporting and surveillance system for tracking all newborns and assisting them with ongoing hearing screening, diagnostic and intervention services. HB 85 allows children to carry and self-administer asthma medication at school. Previously, all asthma medications were stored in a locked container and could only be administered by the school nurse or school official. SB 22 added birthing centers to the list of health facilities eligible for payment of medical assistance for needy persons. HB 185 requires all postsecondary students to be immunized for meningitis. The Legislature also passed resolution HCR 5 urging all communities in Alaska to offer fluoridated water.

/2008/ Several key pieces of legislation were introduced in the first year of a two year cycle, but few progressed through committee hearings. Alaska legislators were focused on passing legislation in support of building the natural gas pipeline and developing a way to fund school districts for more than one year in advance. Bills supporting the re-establishment of the SCHIP program eligibility to its former level of 175% of poverty and removing the statutory clause

preventing adjustments for cost of living received some attention passed and is currently awaiting the Governor's signature. Two other bills related to the SCHIP program propose increasing the eligibility level to 200 and 250% of poverty respectively with "buy in" options for families. In addition, one Democratic Senator has introduced a universal health care coverage bill.

Funding to develop an autism screening and evaluation program was established by a $250K pledge from the Mental Health Trust Authority and $250K from general fund. The Mental Health Trust Authority pledged this amount with the expectation that an additional $250K will be added in general fund dollars as an ongoing base starting in FY 2009. The program will be operated by the Title V MCH agency and will be established in conjunction with The Children's Hospital at Providence as part of their neurodevelopmental diagnostic center.

Senate Bill 73, funding 10 additional positions in the WWAMI program, was easily passed by the legislature and was signed by the governor on March 28, 2007. WWAMI is a cooperative program between the University of Washington School of Medicine and four western states to provide access to publicly supported medical education to those states' residents. Alaska now has 20 positions in the program. One objective of WWAMI is to encourage students to learn and practice medicine in the community

Regulations supporting HB 109 -- Early Hearing, Detection and Intervention bill are near completion and will be posted for public notice in August of 2007. These regulations will become effective January 1, 2008. Regulations requiring the reporting of congenital hearing loss to the Alaska Birth Defects and FAS registry went into effect SFY07. Finally fee regulations to increase fees collected for newborn metabolic screening went into effect February 1, 2007 in support of the addition of Cystic Fibrosis screening to the already expanded metabolic screening panel //2008//.

/2010/ Several health-related bills were passed by the 26th Legislature:
1. Expansion of Denali Kid Care insurance program (SCHIP) to 175% of the current federal poverty guidelines (the federal poverty level had been frozen by statute in the last several years).
2. Approved funding for an autism program.
3. Approved requiring age-appropriate restraints for children in cars.
4. Approved an increase in the minimum wage, to $7.75 an hour, .50 above the federal minimum wage.

In addition, the Governor established the Alaska Health Care Commission in December 2008, to serve as the state health planning and coordinating body, to provide recommendations to the governor and the legislature on a comprehensive statewide health care policy and on strategies for improving the health of Alaskans. //2010//

Current and Emerging Issues
There are several emerging issues in Alaska. Emergency response planning efforts are underway at the state and local levels. The state has prepared a draft Pandemic Influenza Response Plan and a Behavioral Health Emergency Response Plan. These plans do not currently address fragile subpopulations such as CSHCN and there are only 12 pediatric intensive care beds in the state. This is a gap that will need to be addressed in the near future.

/2008/ The All Alaska Pediatric Partnership (AAPP) has taken on the initiative of developing and establishing a more comprehensive disaster plan for children and youth with special health care needs, as well as pregnant women and neonates. The goal is to develop this plan in partnership with the participating hospitals and member state and local agencies who participate in the AAPP partnership within the next fiscal year. //2008//

The prevalence of overweight and obesity among Alaskan youth, based on the 2003 Alaska Youth Risk Behavior Survey, is similar to national prevalence estimates. Reducing childhood

overweight and obesity has been identified as a state priority for the 2006-2010 block grant cycle. State and local systems are collaborating to address this issue. In 2004 the Anchorage School district and the AK Division of Public Health together assess the prevalence of overweight among Anchorage School District children. WCFH continues to work with school districts to monitor this health indicator.

Asthma is among the 10 leading activity limiting chronic conditions in the U.S. The rate of asthma hospitalizations among children less than 5 years of age is higher in Alaska compared to the Nation and nearly 3 times higher than the Healthy People 2010 goal. It is estimated that the prevalence of asthma is 40-90% greater for urban residents. The Alaska Asthma Coalition has implemented public awareness campaigns and worked to achieve passage of a bill allowing children to self-administer asthma medications at school. The Division of Public Health has begun asthma surveillance.

Early intervention services are designed to meet the developmental needs of children from birth to 3 years of age who have a developmental delay (e.g. physical, emotional, communicative, cognitive, or adaptive development). In an average year in Alaska approximately 10,000 live births occur. Of these, about 10% are preterm, almost 6% have low or very low birth weight and 18% have at least one reportable birth defect. Many of these children will qualify for early intervention services. One major barrier to providing early intervention services is the difficulty in recruiting and retaining professional staff in rural communities to conduct screening. Another significant issue is the lack of services for treatment.

//2008// DHSS, in collaboration with tribal health agencies, convened a workshop in SFY 2006 to develop strategies on improving early identification through the EPSDT program. From this workshop, 4 work groups were established to address the early intervention population. They include:

a. Medical Home: Access to an insurance support for medical homes; provision of comprehensive physical and child development services for all children (including children with special health care needs); and assessment, intervention, and referral of children with developmental, behavioral, and psycho-social problems.
b. Mental Health and Social/Emotional: Availability of appropriate child development and mental health services to address the needs of children at risk for developing mental health problems.
c. Early Care and Learning: Development and support of quality early care and learning services for children from birth through 8 that support children's early learning, health, and development of social competence.
d. Family Support & Parenting Education: Availability of comprehensive family support and parent education services that address the stressors impairing the ability of families to nurture and support the healthy development of their children.

The Office of Children's Services was the recipient of the Assuring Better Child Development Screening Academy funded by the Commonwealth Fund. A core Committee was formed consisting of the Medicaid Director, Part C Program Manager, Public Health Deputy Director, Chairperson of the AAP, Alaska Chapter, and the ECCS Coordinator. Medical practices were recruited to participate as pilot sites in doing comprehensive developmental screening during well-child exams. Technical assistance and training will be provided to the pilot medical practices over the coming year. Approximately 20 key decision makers and invested professionals were invited to participate in a Stakeholder Group, which will advise the project. Service providers will be brought together to coordinate responsiveness to referrals and improve feedback to medical homes. Care coordination issues will be identified and solutions will be developed. //2008//

/2009/ Alaska is currently participating in the National Academy for State Health Policy's ABCD Screening Academy. A pilot that includes screening for autism is currently underway in two pediatrician offices in Anchorage and at the Alaska Native Medial Center, a tribally owned and operated healthcare facility that provides a full range of services to eligible Alaska Natives and

American Indians living in Alaska. Pilot findings will be used to expand universal screenings statewide. To date there have been tremendous increases in the use of standardized screening instruments, although information on the number of referrals is still being gathered and analyzed. A universal form for Medicaid, Part C agencies and school districts is being tested -- comments are favorable thus far. The state ABCD team is working on a handout for parents about the importance of following up on referrals from their medical practitioner, and a referral directory has been developed. The ABCD team also met with the Alaska Native Tribal Health Consortium. Although Consortium members are not yet ready to change their screening procedures, they are interested in training on the importance of identifying children early and referring them to appropriate services. The Consortium also recommended that the ABCD state team work directly with Tribal health corporations and engage pediatric providers.

The Children's Policy Team led by the Acting Commission of Health and Social Services convenes monthly to provide for the division's senior executives and their staff to report on a number of children's issues and plans for resolution. Standing agenda items include behavioral health improvements instate for adolescents, particularly in the area of residential treatment centers, progress on autism initiatives, early mental health services for children ages 0-8, and development of systems of care models with a goal towards collaboration between all of the divisions caring for children. The Divisions represented include Public Health-represented by the MCH Title V director, Juvenile Justice, Child Protection, Public Assistance, Behavioral Health, Disability Services, and Medical Assistance. The inclusion of initiatives around autism and early childhood mental health came as a result of the work done in FY07 with the EPSDT workshop technical assistance sponsored by MCHB. // 2009//

B. Agency Capacity

Alaska's state health agency, the Department of Health and Social Services (DHSS) has developed significant capacity to serve women and children from prenatal care and birth through adolescence and adulthood, including health care services for CSHCN. Capacity building begins with recognizing two critical issues the state faces in providing comprehensive care: geographic isolation and low population density. As mentioned in Part III A, Alaska's health care system differs from most other states in that there only two locally organized health departments that function under the umbrella agency of the state health department. Collaborations and partnerships operate between state agencies as well as between the state and the private sector, the non-profit sector, local communities, other public agencies, and families.

The State's CSHCN program delivers a statewide system of services. This capacity has been built on the foundation of strong partnerships and collaboration among federal programs, the state, and Native health care systems community-based organizations. For example, the Section of Women's, Children's and Family Health (WCFH) maintains strong relationships with medical providers and other health care professionals through advisory committees for each of the specialty clinics. NBMS (Newborn Metabolic Screening) Advisory Committee, composed of statewide health providers, parents, laboratory personnel and state staff, met three times in FY05 to discuss issues including hemoglobinapathies, the addition of cystic fibrosis screening to the current screening panel, and the process of tandem mass spectrometry. A sub task force met to improve the mail out and delivery times of the screening cards that are sent from the various birthing hospitals to the lab in Portland, Oregon. Other plans include monitoring the Oregon Public Health Laboratory on their readiness to add Cystic Fibrosis (CF) screening to the current screening panel. This information will play a vital role for the state's CF Task Force in their consideration of adding this condition to the screening panel.

Another excellent example of using partnerships to expand agency capacity is the major role played by the Newborn Hearing Screening Advisory Committee. The Committee initiated the newborn hearing screening program statewide, organized advocates in a six- year effort to successfully pass mandatory hearing screening legislation in 2006, and continues to provide input

in service delivery and program sustainability. Capacity is being expanded through partnership with hospitals and private providers to ensure implementation of the program including follow-up diagnostics and treatment for children who do not pass the initial screens. This newborn screening initiative has been an important and successful partnership between the state, local hospitals, specialty providers and advocacy organizations to provide a comprehensive system of care for children with hearing impairments.

Since October of 2004, the directors of the Division of Health Care Services and the Division of Public Health worked collaboratively on new capacity-expanding projects on issues such as transportation to medical appointments for children (a big expense in the Medicaid budget due to lack of access in many rural villages); recruitment of sub specialists to meet the needs of children who are Medicaid beneficiaries and who require specialized care not available in the state; and a quality improvement project on timely discharge for medically fragile children from the Level II and III NICU. These collaborative efforts have greatly enhanced the capacity to meet the needs of children with special health care needs. This last effort also included staff from the Sections of Licensing as well as the Division of Senior and Disability Services, hospital case managers, and private care coordinators.

/2008/ It was determined that regulation changes to support foster parents who wished to open up a residential treatment home in support of caring for more than the mandatory limit of two medically fragile children were not supported by the Division of Senior and Disability Services. The focus of work is now on recruitment and training of more foster families who are willing to take care of medically fragile infants and children. //2008//

Ongoing support for the EPSDT program resulted in an expansion of services and payments of OT, PT, Speech-Language and Audiology services to schools that enrolled as providers of Medicaid. Nearly 50% of the children in Alaska are enrolled in the Medicaid program and many have special needs. Enhancing the payment methodology for schools will hopefully provide for increased funding to hire additional needed specialists and provide services for children who qualify for an Individual Education Plan (IEP). Working together, the Title V/CSHCN director and Medicaid staff developed and initiated this program in time for the new school year that started in September of 2005. In May 2006 a facilitated state leadership workshop titled "EPSDT and Title V Collaboration to Improve Child Health Outcomes" was held. Participants included staff from the divisions of Public Health, Office of Children's Services, Health Care Services, Public Assistance, and the Commissioner's Office, and representatives of tribal health agencies. Several new strategies to improving childhood outcomes through the EPSDT program were developed and will be pursued in the coming year.

/2008/ An Early Childhood Mental Health (ECMH) cross-systems working group of which the Title V MCH Director was a member, was formed to develop recommendations on mental health services. One of the outcomes of their work has been the crosswalk between diagnostic codes for young children, billing requirements, and the use of appropriate service codes to ensure services for young children. A two-day training was provided for mental health clinicians and early interventionists on this cross walk and other children's mental health training. //2008//

/2009/ The work outlined last year was helpful in the development of the Early Comprehensive Care Systems Grant (ECCS) and the collaboration around piloting a system of continuous developmental screening as part of the ABCD Screening Academy project. In addition, work is in progress in collaboration with the Division of Behavioral Health, the Divisions of Children's Services and the University of Alaska to develop early behavioral health intervention training and curriculum and programs in collaboration with the Early Intervention/Infant Learning programs. //2009//

Regional collaborations have also been useful. The Title V/CSHCN director, newborn screening coordinator, and genetic counselor participated in the initiation of the Western States Genetic Services Collaborative, a regional project focused on expansion of genetics services, education

and collaboration amongst the states. As an infrastructure building activity, the use of the Western States Collaborative Agreement funds is anticipated to be used in support of an additional part-time genetics counselor to assist with the growing clinical needs of the program and allow time to be spent in statewide planning. We will also be forming a genetics advisory committee to address issues around program planning and service delivery goals. The committee will work to design a multi-agency plan for genetic services to provide comprehensive genetic services (clinical, prenatal and disease specific) statewide, to all age groups. The committee will look at long-term feasibility of transitioning clinic services to the private sector, and short term feasibility of broadening local support by hosting clinics at regional hospitals. /2009/ The previous goals identified with the last funding cycle continues, with a focus on improving services to be more family-centered and supportive. The collaborative is working on standardization of data collection to achieve comparability of data across states. //2009//

/2010/ WCFH is collaboratiing with the Indian Health Service, Oregon Health & Science University (OHSU), and the Oregon Public Health Lab to address the growing number of infants with carnitine palmitoyl transferase 1 (CPT1) deficiency.
A metabolic geneticist from OHSU made several trips to Alaska to meet with providers and families of children with CPT1 to discuss the condition and potential consequences of the condition. As the number began to grow higher, it was decided that clinics would be overwhelmed with families and a different approach would need to be taken. A DVD was produced with funding from the Western States Genetics Collaborative, Norton Sound Regional Corporation, and the Alaska Native Medical Center to provide education to families of infants diagnosed with CPT1, village health aides, and practitioners. //2010//

The MCH-Epi (Epidemiology) Unit within WCFH provides data collection, analysis, research, and publication services to program managers for program monitoring and policy development. Significant work was accomplished in collecting, analyzing and reporting data from the Alaska Birth Defects Registry and the Fetal Alcohol Syndrome database including: publishing prevalence estimates for all major birth defects (as defined by the National Birth Defects Prevention Coalition) in the journal Teratology;completing a comprehensive descriptive analysis of ABDR data including trend analysis, regional distribution and prevalence of major birth defects by important demographic and birth characteristics; completing an analysis of trends in the occurrence of neural tube defects following folic acid fortification recommendations and publishing the findings in an Epidemiology Bulletin; and adding approximately 3,500 referrals to the FAS referrals database and conducting chart abstractions to identify a total of 92 children born between 1995 and 2002 who met surveillance criteria for FAS. Future plans are to link the birth defects databases with program databases to enable evaluation of program services. Potential collaborative projects include linkages with databases from Infant Learning Program (ILP), Women Infants and Children (WIC), Genetic and Specialty Clinics, Universal Newborn Hearing Program and Newborn Metabolic Screening Program. Other planned collaborations are to work closely with FAS prevention programs and diagnostic teams to provide surveillance data for monitoring program efforts and to expand our already strong relationship with the Division of Behavioral Health to expand distribution of surveillance findings and to begin working with agencies and communities to illustrate how our data can be used to plan and evaluate prevention efforts and policy.

The development of pediatric asthma surveillance systems was implemented under the State Systems Development Initiative (SSDI). MCH-Epi collaborated with Medicaid services and Vital Statistics to link Medicaid and birth certificate data to evaluate whether birth outcomes -- specifically low birth weight and preterm birth -- are associated with development of asthma. The analysis will be published in a peer-reviewed article (Annals of Asthma, Allergy, and Immunology) and was used by the non-profit Southcentral Foundation, an Alaska Native non-profit health corporation, to support current intervention policies related to asthma. MCH-Epi staff collaborated with the Anchorage School District to establish an asthma screening questionnaire for administration at enrollment and assisted with the review of regulations allowing children to self-administer asthma medications in public schools. WCFH was a finalist for a Merck Foundation

grant to establish a pediatric asthma control program in the state. Finally, the MCH-Epi unit manager is Chair of the Surveillance Subcommittee of the Alaska Asthma Coalition and member of the Board of the Allergy and Asthma Foundation of America, Alaska Chapter.

/2010/ An application has been submitted for a five-year CDC grant to establish an asthma surveillance and intervention program, to be shared between WCFH and the Section of Chronic Disease Prevention and Health Promotion. Proposed activities include: preparing an annual asthma report; linking data sets such as BRfSS, vital statistics, WIC, hospital discharge database, Medicaid and the toddler survey; estimating prevalences; analyzing risk factors and outcomes. The award announcement will be in August 2009. //2010//

/2009/ During FY 2008 the MCH-Epi Unit established the Alaska Surveillance of Child Abuse and Neglect (SCAN). The purpose of this surveillance program is to provide reliable, accurate, and consistent data of child maltreatment through an integrated and centralized data depository. Due to jurisdictional bounds, regulatory agency responsibility, and varying definitions, organizations that identify or respond to maltreatment generally capture only a portion of the overall picture of child maltreatment. The Alaska SCAN system relies on linking the data of these various organizations which include but are not limited to, hospital in-patient records, emergency department records, police and homicide reports, child death review finds, and child protect services reports. Alaska SCAN is being implemented in two main phases. Phase I covers fatalities resulting from maltreatment and Phase II will incorporate injuries resulting from maltreatment. Phase I data are collected annually by linking multiple existing data sources. These data will be analyzed descriptively and linked with additional epidemiological data tools such as the Pregnancy Risk Assessment Monitoring System (PRAMS) to identify other elusive trends. The systematic collection of information and application of standardized sensitive public health definitions promotes data consistency over time and enables individual programs to understand the impact of their interventions, target specific populations in greatest need, implement, monitor, and evaluate scientifically based community focused initiatives, as well as advocate for resources based on reliable and consistent information.

Also in FY 2008, the The MCH-Epi Unit added a CSTE Fellow to its staff. The additional staffing capacity is being used to initiate a surveillance program for preterm birth. Birth certificate data will be analyzed. //2009//

Data provided by MCH-Epi also assisted in supporting the Medicaid staff's desire to maintain benefits including dental care for pregnant women, and staff was able to articulate more clearly the benefits of prenatal care in response to questions from legislators.

/2010/ The 2008 Alaska Maternal and Child Health Data Book: Health Status Edition was published in Spring 2009 (available at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/2008.htm). Wherever possible, indicators are stratified by Alaska Native status or geographic region in order to illustrate differences between cultural subpopulations or rural/urban residency. The MCH-Epidemiology Unit assists the Alaska Native Epi Center by sharing data, meeting with the staff yearly to share research ideas, and collaborating on biennial conferences.

Most of the applied research conducted by the MCH Epidemiology Unit includes data stratification by Alaska Native status. For example, an analysis of birth certificate data identified 3 new risk factors associated with elevated risk of postneonatal mortality among Alaska Native population. Analysis of the Alaska Birth Defects Registry showed that Alaska Native infants have higher rates, compared to non-Native infants, for 10 of the 15 most commonly identified major congenital anomalies. Collection and analysis of data related to specific congenital anomalies recently led to a collaboration with Washington University researchers to investigate risk factors for Hirschsprung's Disease. (Comprehensive data from the Birth Defects Registry is available at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/2005.htm). MCH Epidemiology Unit

recently collaborated with CDC and Alaska Native health organizations on a randomized clinical trial to determine the contribution of Helicobacter pylori (Hp) infection to iron deficiency and anemia (prevalences among Alaska Native children and pregnant women are 10-fold higher than other US populations). The results of this study had a direct impact on clinical practice. (Citation: Gessner BD. Geographic and racial patterns of anemia prevalence among low income Alaskan children and pregnant or postpartum women limit potential etiologies. J Ped Gastro Nutr. In press)

Unit staff analyzed vital records, medical records, autopsy reports, and first responder reports for 93% of Alaskan infant deaths occurring during 1992-2004 for risk factors associated with deaths while bed sharing. The analysis led to a state policy contrary to national recommendations set forth in 2005 by the American Academy of Pediatrics regarding bed sharing with infants. The Alaska Division of Public Health recognizes the profound cultural, social and potential health benefits (such as breastfeeding and parent-infant bonding) associated with bed sharing. As a result of the Unit's research, the state has established a Safe Sleep Initiative to further clarify its recommendations and target public education messages to families engaging in high risk behaviors. //2010//

Coordination of health components and coordination of health services at the community level occurs through a mix of technical training, partnerships and direct grants to local providers. In many frontier areas, medical services are limited to a small clinic staffed by a Community Health Aide with basic training in primary, preventive and emergency medical care. Due to chronic staff shortages, unpredictable weather, and high cost of travel, villages and communities may receive a visit from an itinerant Public Health Nurse as frequently as monthly or as infrequently as bi-annually. The inability to access specialty care poses significant hardships for CSHCN. To address these challenges, a coalition of state and private agencies developed a broader definition of a medical home for Alaska CSHCN: "The medical home is where a child with special health care needs and his or her family can count on having medical care coordinated by a health care professional they trust. It is not a building, house or hospital, but rather an approach to providing quality and coordinated services". Itinerant public health nurses visit most of Alaska's rural communities providing the "medical home" for many of Alaska's children and families. An R.N., Nurse Practitioner, Community Health Aide or Physician's Assistant provides primary and preventive care in many cases. Primary health care providers and families work as partners to identify and access all of the medical and non-medical services needed to help CSHCN achieve their potential. Working from this base, a coalition of providers are currently engaged in building a base of specialists and sub-specialists in children's health, holding specialty clinics in rural communities, coordinating specialty care with families either on an itinerant basis or helping families access services in larger communities. As the FQHCs and community health centers before more firmly established, the Title V and CSHCN staff is working with them on developing greater competency and capacity to care for CSHCN, adolescents and prenatal women.

Specialty clinics are sponsored throughout the state since these services are not available locally. Multidisciplinary evaluations are conducted at Cleft Lip and Palate Clinics in Anchorage, Bethel and Fairbanks. Children receive consultations at the Neurodevelopment Clinics in Dillingham, Fairbanks, Juneau and Ketchikan and consultations at Neurology Clinics in Fairbanks. Additional hours for parent navigation for the CL &P clinic were offered in FY 06 to assist in families in getting their treatment plans initiated, finding funding for under insured or not insured clients if necessary and navigating the health care systems as needed. Nearly 65% of all families seen at the CL/P clinic requested assistance of the parent navigators. These paraprofessionals are provided as a result of a contract with the Stone Soup Group using Title V funds. The use of parent navigators expanded to families in SFY 2007 with newborn hearing loss and those with other special need conditions. A pilot is being considered with Medicaid services to offer parent navigation for families who have children with chronic health conditions such as diabetes, cancer and asthma in coordination with nursing case management.

/2008/ parent navigation services will be added with the expansion of the autism screening and

evaluation services that will be offered at the Neurodevelopmental Center at The Children's Hospital at Providence in addition to the outreach clinics offered in smaller communities across the state. //2008//

/2009/ Grant funds were awarded to The Children's Hospital at Providence's Neurodevelopmental Center in support of expansion of diagnostic services. The expanded program, Providence Autism Diagnostic Network, is a collaborative effort that integrates psychiatry, psychology, neurology, physical, speech, occupational therapy and parent navigation services. They have been able to develop a more efficient process for diagnosing children with autism and are working towards increasing the numbers of children seen. The second stage of this effort will be offer more screening services by some members of the team in areas outside of Anchorage. Strategies for this are in process for SFY2009. //2009//

/2010/ Beginning in June of 2009 additional autism screening and neurodevelopmental disorder clinics will be scheduled for an additional 7 communities across the state. Clinics will be held in community health centers, tribal health centers (many of which are community health centers) or in public health centers. An advanced nurse practitioner experienced in screening, diagnosis and ongoing management of children with these conditions will be traveling to sites to work along side the Parent Services manager and a parent navigator. Children are referred by local health providers, tribal community health aides, public health nurses, school psychologists or early intervention staff for a screening and are linked with a medical home to assure ongoing follow up. Clinic appointments are designed to give time for the child to be screened as well as time with parents/caregivers to address their concerns and establish a plan. Outcomes may include referral to the Providence Autism Diagnostic Network or Neurodevelopmental center for further testing and evaluation; referrals to behavioral health treatment services, updating an IEP and work with school psychology services or linkage with early intervention. The clinics are designed to link with the early identification and referral efforts in development as part of the capacity building for autism grant funded by HRSA/MCHB "Combating Autism Initiative". //2010//

The Newborn Metabolic Screening (NBMS) program manager continued a series of educational efforts around the state that targeted medical staff involved in the collection process. These efforts included education on proper collection techniques, transport issues, and how to reduce the number of hospital discharge refusals. These presentations often provided continuing education credits for medicine, lab and nursing. As a result of these efforts, the number of refusals at discharge fell to near zero in most communities. A brochure designed to meet a lower literacy level was developed, field tested, and distributed to prenatal providers. Brochures holders were also developed to hold both the Newborn Metabolic screening brochure and the Newborn Hearing Screening brochure and distributed widely across the state to family practice physicians, obstetrical providers, nurse midwives, direct entry midwives, public health nursing centers, and any office where prenatal patients might visit. Continuing education efforts regarding the lesser-known metabolic conditions identified through expanded testing with tandem mass spectrometry will be the focus this coming fiscal year. Education will target the confirmatory testing process including proper specimen collection and shipment to the appropriate testing facility.

Site visits were conducted by the Early Hearing Detection and Intervention (EHDI) Program Manager and the EHDI Surveillance Manager to communities implementing the screening programs to provide technical assistance and connect providers involved in the EHDI process beginning at the screening facility, through the diagnostic phase, and ending at early intervention. Screening is now performed at all birthing hospitals/communities in the State. To assist facilities with annual birthing rates of less than 50 begin newborn hearing screening, the EHDI Program purchased five portable hearing screeners and placed them in these five communities. The program purchased two additional portable screeners for placement in public health nursing centers in areas with high home/midwifery center births. Education efforts to the direct-entry midwives showed enthusiasm and willingness to send their clients to public health nurses (PHN)

for hearing screening. The EHDI Program developed a video for rural Alaskan healthcare providers, termed Community Health Aide/Practitioners (CHA/Ps). The video identifies newborn hearing screening, speech and hearing developmental milestones, high risk factors for late onset and/or progressive hearing loss, and proper protocol for CHA/Ps if a hearing loss is suspected in a child. The EHDI Program Manager worked with the CHA/P Program to disseminate the video through teleconference presentations with CHA/Ps, mail outs for continuing medical units, and in-person presentations. Using footage from the video, the EHDI Program developed one radio public service announcement (PSA) and one television PSA. Using the PSAs, the EHDI Program is conducting a statewide media campaign focused on rural Alaska to stress the importance of screening newborns at birth for hearing loss. With the implementation of the web database, training for facilities that cannot send someone to Anchorage will be a major activity. The EHDI Surveillance Manager travels to those communities to provide hands on training. It is anticipated that all birthing facilities will be online and reporting through this system by fall of 2005. Tracking and follow-up activities will be enhanced with this system in an attempt to meet the National EHDI 1-3-6 goals. The Surveillance Manager will be able to perform monthly QA reports and get back to facilities in a timelier manner regarding follow-up screening and diagnostic procedures. Continued educational efforts to ensure that members of the health community are aware of hearing screening, where to go for screening, where to go for diagnostic testing, and milestones to watch for in children at risk for progressive/late onset hearing loss.

/2008/ All birthing communities have received training on data entry and the web site and are fairly current with their entry. Developing site specific systems for training when there is staff turnover continues to be a challenge, however quarterly teleconferences and offering training in Anchorage at least yearly has assisted hospitals and communities to stay current. Linkages with the Newborn Metabolic Screening data are near completion. This will provide for ready access to viewing both sets of data and provide a web based data system to conduct surveillance and assure follow up. //2008//

/2009/ Full integration of the newborn metabolic database into the newborn hearing screening database is nearly complete and working well. Report generation is smoothing out for providers. The data integration will assist us in tracking services to all newborns offered by the MCH programs over time and hopefully will be linked with other reporting systems such as the immunization registry. The EHDI staff worked with community audiologists and the contractor to redesign more user friendly audiology data entry pages in the hopes of increasing the completion rate. An agreement was finally signed between the Division of Public Health and the Office of Children's Services (child protection) to share data between the state's Infant Learning Program (early intervention) located in OCS, with the state's EHDI program. //2009//

/2010/ The EHDI program manager continues to meet with subcommittees. The Diagnosis to Intervention Task Force identified three process improvements that can be made to strengthen services. Representatives from the Family Support Task Committee were sent to the National Investing in Families Conference. The parent committee prepared a parent survey. The EHDI program managers continues to collaborate with other organizations through participation on hearing-related committees. A data sharing agreement was implemented with the Early Intervention/Infant Learning Program. EI/ILP information will be tracked with the EHDI software, this will improve the referral process from diagnosis to intervention. //2010//

WCFH staff continues to work with communities and genetics providers from Seattle Children's Hospital and Medical Center to address problems with small clinics where cost of transportation and small population base make face-to-face service delivery time consuming and costly. Clinic days, including additional days for Metabolic Genetics Clinic, will be reassigned to hub centers, or areas of growing population need. We will also again pursue adding clinic days to Alaska Native Tribal Health Consortium in support of native clients being seen in their provider network location. In addition, the program will target underserved areas of the state through the development of educational materials for remote areas and will focus on one or more underserved areas of the

state with provider information, to improve awareness of available services and internet/distance resources.

Pediatric Cardiac Clinics in Southeast Alaska were privatized in FY2005 since the number of resident in state pediatric cardiologists increased to 3 in FY 2005. The state previously contracted with Children's Hospital and Regional Medical Center (CHRMC) in Seattle to bring pediatric cardiologists to Juneau, Ketchikan and Sitka for clinics. CHRMC will continue to offer clinics in these communities through their outreach program. The contract dollars will be shifted to contract with non-profit agency (to be determined) for parent navigation services for families whose children have complex neurological issues and those with hearing loss.

Community-based services are integral to a comprehensive system of preventive and primary care services for our four primary populations: that of pregnant women and infants, women across the lifespan, children and adolescents, and children with special health care needs. One of the most active community-based health care systems is the Alaska Public Health Centers. The state currently supports Public Health Centers in 23 communities and offers itinerant reproductive health and immunization services to remote/frontier communities that do not have a health center. Some of the centers also offer EPSDT exams for children. The Public Health Centers are staffed by Public Health Nurses and the Division of Public Health, Section of Nursing, oversees staffing of the centers. WCFH and the Section of Nursing have long been partners in identifying and providing needed services for the MCH population. For example, family planning services are offered at Public Health Centers and contraceptives purchased with MCH block grant funds support that effort. Public Health Centers and Public Health Nurses are also the state's frontline providers of prenatal care, immunizations, referrals for specialty care, EPSDT services, maternal health services, etc. Public Health Nursing is frequently contacted when following up with abnormal screens, and lab data. The public health nurses are also critical in helping to coordinate the specialty and genetics clinics held in the regional hubs.

The state offers grants to local health care providers and organizations to deliver direct services to women and children. These grants build health care capacity at a local level by supporting local expertise and health care facilities as well as supporting the economic base of small communities with jobs and career options for local populations. Direct grants to local communities are available for Infant Learning Programs, WIC, Healthy Families, school-related initiatives, family and community nutrition, breast and cervical cancer screening outreach and oral health. These locally based efforts are also important to bring culturally competent care to predominately Native communities in remote and frontier areas of the state. For example, the state supports training and education programs, some through the University of Alaska distance delivery or on-campus programs, to educate and train paraprofessionals to deliver WIC, Infant Learning, community health aides, and professional services such as nursing, early childhood teachers and others.

The health of newborns and young children is another capacity building effort important for the state health agency. Outreach efforts through the SCHIP program and Denali KidCare have been instrumental in enrolling pregnant women in the health insurance program so they can access needed services. The EPSDT program promotes important prenatal care and provides outreach so newborns can be enrolled in Denali KidCare soon after birth. Health information is provided on a regular basis to Medicaid/Denali KidCare recipients on well-child exams, health and safety and how to access medical care through Medicaid enrolled providers. All of these efforts require partnerships between the various state agencies administering the programs, local providers and local program administrators.

The DHSS reorganization of FY 2003, while disruptive in some ways, also afforded new opportunities for collaboration between state agencies to improve policy decision making. Staff responsible for MCH programs provided consultation and feedback in the area of Medicaid provider services including dental services, family planning, prevention and primary care services, and treatment services such as audiology, speech-language; laboratory billing and payments;

regulations regarding services for children; transportation program changes; the Medicaid waiver program; medical services for CSHCN, and several others. Enhancing the Medicaid staff's understanding of how Medicaid payment policies impact public health outcomes was very rewarding. As a result, MCH program capacity in prevention and primary care services was expanded from a policy and payment perspective. The most significant challenge of the reorganization was the loss of personnel capacity to take on new public health projects or respond to new grant opportunities. With the loss of staff positions and the lack of connectivity to prior programs, such as early intervention and WIC, the ability to maximize resources, both capital and personnel, is more difficult in some areas.

Over the coming years, Alaska will be addressing significant funding issues that may affect the state's capacity to provide services to women and children. At present, 70% of the funding for WCFH is from federal grants. Over time, state general fund dollars have been redirected to other state departments. Strategic planning regarding long term funding and sustainability will be undertaken in the Fall of 2006.

/2008/ The MCH Title V Director led a work group to develop a public health logo, outreach plan and contact data base as well as an Outreach Tool kit for public health staff to use in their presentations in support of educating the public about the role of public health in communities. The executive leadership team identified this as the first step in developing an outreach plan that would look for additional funding partners //2008//.

/2010/ The MCH Title V/CSHCN program was successful with the closure of the legislative session to be awarded general funds as part of the base budget in support of the Alaska Birth Defects/FAS registry. The program has been 100% funded for the last four fiscal years by the MCH Title V Block grant. In addition, the program now receives $500,000 in general fund/mental health dollars supporting expansion and capacity building for autism and neurodevelopmental conditions. This is been a significant help in assuring long term sustainability for programs and system development in support of children with special health care needs. //2010//

/2008/ A full time perinatal nurse consultant was hired as was a ¾ time Adolescent Health manager. The two positions supporting the Toddler Survey (CUBS) were also filled and a new CSTE CDC fellow will be starting in mid August of 2007. Alaska is currently a finalist for assignment of a CDC Prevention Specialist. Notification will occur in August of 2007. //2008//

/2009/ Four new staff positions were added. As a result several new programs were initiated, including establishment of a Perinatal Advisory Committee, creation of the Alaska Surveillance of Child Abuse and Neglect, initiation of a preterm birth surveillance program and start of an adolescent health program. In SFY09 a nurse consultant position to support school health and the EPSDT program and a new autism manager will be hired. //2009//

/2010/ Three new programs were added to WCFH, as a result of staff additions. The focus of the Combating Autism Program will be on early childhood screening and increasing access to services. Capacity will be expanded through collaborations with other agencies and organizations such as the Governor's Council on Disabilities, the Rural Ad Hoc committee, the interdepartmental early childhood coordinating council, Family Voices, and the Family and Community on the Comprehensive Plan for School Health and Safety. The manager will also oversee clinics in Fairbanks and Juneau and plan for 7 new rural outreach screening clinics, create educational resources for best practices, and conduct family follow-up.

The Adolescent Health Program collaborates with the Division of Public Assistance to reduce the rates of teen births in rural areas of the State. In addition, the Adolescent Health Program has been focusing on promoting healthy relationships and youth development as a way to reduce teen births. Work is accomplished in part through grants

to communities, train the trainer sessions, targeted media campaigns designed with the help of youth, collaborations with a large network of providers and youth, needs assessments, and on-site technical assistance. A youth advisory committee will start meeting in the fall to help the Adolescent Health Program best meets its goals. The website is at http://www.hss.state.ak.us/dph/wcfh/adolescent/default.htm

Finally, the School Age Health and Well Being Program is headed by a nurse consultant. Program objectives are still being formalized, but will target best practices, formulating policy recommendations, and EPSDT outreach. //2010//

An attachment is included in this section.

C. Organizational Structure

Organizational charts for the Alaska Department of Health and Social Services (DHSS), the Division of Public Health, the Section of Women's, Children's and Family Health, and the Office of Children's Services can be found under Other Supporting Documents. The WCFH Organizational Chart includes positions by program as well as job classification.

Alaska's state health agency, the DHSS, is one of 15 departments comprising the Executive Branch of Alaska's state government. The Governor directs the activities of each of these departments through appointed cabinet level commissioners. The DHSS organizational structure is broken down into Divisions with an appointed director to oversee all activities for their Division. The Division of Public Health within the DHSS is charged with primary responsibility for MCH programs although two significant programs, the Early Intervention/Infant Learning Program and WIC, reside in the Office of Children's Services. An organizational chart for the Department is attached.

Alaska differs from most states in that it does not have county health departments that function under the administrative arm of the state health agency. Alaska's health care system rather is a mix of direct state, tribal or federal, local health care agencies and private practice health care providers. The state operates local public health centers in 23 communities and offers itinerant public health nursing services for those communities not served by public health centers. Two urban communities have locally organized health departments, the Municipality of Anchorage and the North Slope Borough. Federally funded hospitals provide health care services to Alaska's military and Native populations. Additionally, health care services are provided to Alaska Natives through health clinics operated by the Indian Health Service or Alaska Native Health Corporations. Other services for MCH populations are provided by non-profit agencies using grant funds from state, federal or other non-governmental funding sources. The state, then, can be involved in providing health care services on numerous levels, as a direct service provider, through grants, or as a partner with Native, federal and private health care organizations in the planning, provision and coordination of health care services.

Currently, the responsibility for some of the state's MCH Title V program and the position of Title V and CSHCN director reside in the Division of Public Health (DPH). Decisions regarding funding allocations for the FFY07 Title V grant will be made by the MCH Title V Director with input from the Director of Public Health and approval from the assistant commissioner

For those programs funded by the Federal-State Block Grant Partnership budget, the state's administrative role is as follows:
1. Early Intervention/Infant Learning program. This program is located in the Office of Children's Services. The state general funds spent on this program provide a large portion of the state match of the Block Grant and portion of the Federal-State Partnership. While DHSS is the umbrella organization for both the Title V administrative organization (i.e. the Division of Public

Health) and the Office of Children's Services, there will continue to be a coordinated effort to provide information required for the Block Grant application both programmatically as well as fiscally.
2. Women, Infants and Children (WIC) Nutrition program. This program is located in the Office of Children's Services. There are some state funds that support this program in the form of team nutrition grants, however the bulk of funding comes from the USDA. The WIC program and the other former MCH programs continue to collaborate on activities and participate jointly on statewide committees.
3. Maternal-Child surveillance activities. These activities are located in DPH (Division of Public Health), Section of Women's Children's and Family Health (WCFH).
4. Family Violence Prevention and Childhood Injury Prevention are located in DPH, Section of Injury Prevention and Emergency Medical Services.
5. Children's Behavioral Health is located in the Division of Behavioral Health.
6. Family Nutrition, the Early Comprehensive Care Systems (ECCS) grant, the Early Intervention Program and the Healthy Families Home Visitation program are located in the Office of Children's Services. The Title V Director and some WCFH staff actively participate in work conducted with the ECCS and Early Intervention program.
7. Primary MCH programs are located in DPH Section of WCFH These include Newborn Metabolic Screening, Newborn Hearing Screening (EHDI), Specialty Clinics, Birth Defects and Genetics Clinics, Oral Health for Children and Adults, Family Planning, Abstinence Grant administration, Adolescent Health, and the Breast and Cervical Cancer program and Perinatal and Women's Health

The development of new working relationships in support of maintaining an MCH presence has continued to move forward despite significant staffing changes in other divisions. Ongoing efforts in this arena will continue over the coming fiscal year.

/2009/ Updates to the programs listed previously include:
1. Women, Infants and Children (WIC) Nutrition program has been relocated to the Division of Public Assistance as a result of a decision made by the Division of Finance. The MCH Title V program continues to look for ways to collaborate with the WIC program, however this has been limited to breast feeding promotion and support.
No other organizational changes occurred this fiscal year//2009//.

/2010/ A broader focus on adolescent health is being developed, supported by the new hire of a full time adolescent health program manager. In addition to teen pregnancy prevention, the manager is working collaboratively with the Domestic Violence Network on their teen intimate partner violence and data rape prevention program. She is also collaborating with the Section of Chronic Disease on obesity prevention and healthy weight efforts, as well as smoking cessation. She is working with the Division of Behavioral Health on transition issues for adolescents aging out of services. The manager is in the process of developing a state-wide, youth led advisory committee and is completing her need assessment of teen health issues.

A school nurse consultant for the state was also hired this year. This employee has 19 years of school nursing experience in smaller communities as well as some rural/bush school nursing experience. She is in the process of conducting her needs assessment and has already identified several issues common to school districts that have school nurse and those that do not. These include, but are not limited to, consistent and comprehensive disaster plans, administration of medication policies, record keeping for student who visit the school nurse or school offices, and processes for conducting "physical exams" as required by state statute for all kindergartners. The school nurse consultant works closely with the Department of Education and Early Development health education staff as well as colleagues in the Section of Chronic Disease/Division of Public Health. The work completed is also in support of the implementation of the CDC coordinated school health model, despite the fact that Alaska is not a funded state.

Finally, two additional FTE's were added in support of autism capacity building and expansion efforts this year. One public health specialist II position was filled in November with a candidate who has over 10 years of experience working with and coordinating services for parents using a family-centered, culturally competent parent navigation approach. She has taken the lead as the program manager for the Combating Autism Grant initiative funded by HRSA as well as coordinating the expansion of screening and diagnostic services for children suspected with autism spectrum disorder and other neurodevelopmental conditions across the state of Alaska. She is also the lead for transition issues for children with special health care needs working with the Division of Behavioral Health and the Governor's Council on Special Education and Disabilities. The second position, a public health specialist I position is currently in recruitment and expected to be filled by mid summer. This position will focus specifically on the HRSA/MCHB grant goals and objectives and will assist in many of the above functions as well as capacity building of parent services.

For 2010, an additional FTE will be added in support of the Alaska Surveillance of Child Abuse and Neglect SCAN program. Currently this program is managed by a CDC Prevention Health Specialist whose term will be ending in September of 2009. A recruitment process will be initiated to hire a full time public health specialist for this program. The purpose of Alaska SCAN is to provide reliable, accurate, and consistent data of child maltreatment through and integrated and centralized data depository. A complete description of this program can be found in the Section B. Agency Capacity for 2009. //2010//

An attachment is included in this section.

D. Other MCH Capacity

Title V MCH programs are currently implemented by three divisions within the Department of Health and Social Services: the Division of Public Health, the Office of Children's Services, and the Division of Health Care Services. These programs were all formerly within the Division of Public Health, however, a major departmental reorganization in 2003 shifted several programs and Title V oversight to other existing or new divisions. In 2005, another smaller scale but significant reorganization returned several MCH programs to a new section (Women's, Children's and Family Health) within the Division of Public Health. From 2003 to 2006 a significant number of positions were eliminated, left vacant, had a change in position description or experienced turnover.

Several MCH Programs were transferred into the new Section of WCFH in July 2005 as noted in last year's notes. The current staffing of Title V programs is as follows:

1. Division of Public Health
1a. Section of Women's, Children's and Family Health (49 positions):
Section Chief (Title V/CSHCN Director) - 1 position.
MCH Epidemiology Unit:
Administrative Support - 1 position (vacant) ; PRAMS - 2 positions; Alaska Birth Defects Registry (ABDR) and FAS Surveillance Project -- 4 positions (1 vacant and one on active duty with the Army) ; Pediatric Physician Epidemiologist - 1 position; Maternal-Infant Mortality Review/Child Death Review Committee - 1positions; MCH Indicators Surveillance position - 1 position; MCH Epidemiologist - 1 position; Toddler Suvey (CUBS)- 2 positions; Public Health Specialist -- 1 position (vacant); CDC/CSTE Fellow1 position; CDC Prevention Specialist-1 requested
Women's and Adolescent Health Unit:
Administrative Support - 1 position; Breast and Cervical Cancer Screening program -- 9 positions; Family Planning -- 1. 25 positions; Perinatal Health -- 1 position ; Health Program Manager -- 1 position (vacant); Reproductive Health Partnership

0.75 position. Adolescent Health- 1 position; Graduate Intern position-1 position
Children's Health Unit:
Administrative Support -- 1 positions; Newborn Hearing Screening - 1. .5 positions; Newborn Metabolic Screening -- 1..5 positions; Genetics and Birth Defects Program - 1 position; Pediatric Specialty Clinics - 0.75 positions; Oral Health - 3.5 positions (1 in Juneau and 2.5 in Anchorage).
Section Administrative Support:
Administrative Officer: 1 position; Administrative Assistant/Supervisor: 1 position; Administrative Clerk II: 2 positions; Accounting Clerk: 1 position (vacant)

1b. Section of Injury Prevention and Emergency Medical Services (2 positions)
Alaska Family Violence Project - 2 positions; Child Injury Program - 1 position.

2. Office of Children's Services: Prevention Services (19 positions)
Unit Manager - 1 position; Administrative Support - 2 positions; Community and Family Nutrition Services - 1 position; WIC Nutrition Programs - 10 positions in Anchorage and Juneau; Early Childhood Comprehensive Systems Program - 1 position; Early Intervention/Infant Learning Program -- 4 positions; .

3. Division of Health Care Services (2 positions)
EPSDT program -- 2.5 positions; .

4. Division of Behavioral Health: 1 position
Suicide prevention support .5 position.

All of the Information Technology positions (analyst programmers, web masters, etc.), administrative assistants, accountants, and grants and contracts administrators were centralized under one Division of Financial Management services reporting to the Assistant Commissioner of DHSS. Previous to SFY05, these positions were decentralized to the divisions, sections, and programs of the department

/2009/In SFY07, additional programmatic responsibilities were incorporated into the section, most notably the Autism program. One additional position has been added for now to support the expansion of assessment and diagnostic capacity. An additional position may be considered to add screen capacity later in the year. Funding for the Autism program is coming from the Mental Health Trust Authority and General Fund dollars. This program works closely with the state's early intervention program. For SFY09, an prior position will be reclassified to handle school health issues and assure that we are meeting the EPSDT outreach and support regulations outlined in our state Medicaid plan. A total of 47 FTE's are currently budgeted for SFY09. Depending on the success of grant awards applied for, additional FTE's may be added.
1a. Division of Public Health-Section of Women's, Children's and Family Health (47 positions):
Section Chief (Title V/CSHCN Director) - 1 position.
MCH Epidemiology Unit: Administrative Support - 1 position; PRAMS -- 2.5 positions; Alaska Birth Defects Registry (ABDR) and FAS Surveillance Project -- 3 positions; Pediatric Physician Epidemiologist - 1 position; Maternal-Infant Mortality Review/Child Death Review Committee -- 1 position; MCH Indicators Surveillance position - 1 position; MCH Epidemiologist - 1 position; Toddler Survey (CUBS)- 2.5 positions; Public Health Specialist -- 1 position (vacant); CDC/CSTE Fellow 1 position; CDC Prevention Specialist-1 position
Women's and Adolescent Health Unit: Administrative Support - 1 position; Breast and Cervical Cancer Screening program -- 8.5 positions; Family Planning -- 1.25 positions; Perinatal Health -- 1 position; Reproductive Health Partnership
0.75 position. Adolescent Health- 1 position (Vacant); Intern position-1 position
Children's Health Unit: Administrative Support -- 2 position; Newborn Hearing Screening -- 2.5 positions; Newborn Metabolic Screening -- 1.5 positions; Genetics and Birth Defects Program - 1 position; Autism: 1 position; Pediatric Specialty Clinics - 0.5 positions; Oral Health - 3.5 positions (1 in Juneau and 2.5 in Anchorage); School Health/EPSDT: 1 position (Vacant).
Section Administrative Support:

Administrative Assistant II: 1 position (Vacant); Administrative Assistant: 1 position; Administrative Clerk II: 2 positions; Accounting Technician: 1 position

1b. Section of Injury Prevention and Emergency Medical Services:
Alaska Family Violence Project - 2 positions; Child Injury Program - 1 position.

2. Office of Children's Services: Early Childhood Comprehensive Systems Program - 1 position/ABCD Screening Academy/Early Childhood Behavioral Health; Early Intervention/Infant Learning Program -- 4 positions.

3. Division of Health Care Services
EPSDT program: 1.5

4. Division of Behavioral Health:
Suicide prevention support .5 position.

5. Division of Public Assistance: Prevention Services
Unit Manager - 1 position; Administrative Support - 2 positions; Community and Family Nutrition Services - 1 position; WIC Nutrition Programs - 10 positions in Anchorage and Juneau.//2009//

/2010/ In SFY09, WCFH expanded program responsibilities in the areas of school health and autism. Two FTE's were added: a School Nurse/School Health consultant and an Autism program manager (through the Combating Autism State Implementation Grant). A total of 44 FTE's are currently budgeted for SFY 2010. Depending on the success of grant awards applied for, additional FTE's may be added.

1a. Division of Public Health-Section of Women's, Children's and Family Health (44 positions):
Section Chief (Title V/CSHCN Director) - 1 position.
MCH Epidemiology Unit: Administrative Support - 1 position; PRAMS -- 2.5 positions; Alaska Birth Defects Registry (ABDR) and FAS Surveillance Project -- 3 positions; Pediatric Physician Epidemiologist - 1 position; Maternal-Infant Mortality Review/Child Death Review Committee -- 1 position; MCH Indicators Surveillance position - 1 position; MCH Epidemiologist - 1 position; Toddler Survey (CUBS)- 2.5 positions; CDC/CSTE Fellow - 1 position; CDC Prevention Specialist -1 position
Women's and Adolescent Health Unit: Administrative Support - 1 position; Breast and Cervical Cancer Screening program -- 8.5 positions; Family Planning - 1.25 positions; Perinatal Health -- 1.5 position; Reproductive Health Partnership
0.75 position; Adolescent Health- 1 position;
Children's Health Unit: Administrative Support -- 2 positions; Newborn Hearing Screening -- 2.5 positions; Newborn Metabolic Screening -- 1.5 positions; Genetics and Birth Defects Program - 1 position; Autism/Neurodevelopmental clinics - 2 positions (one vacant); Oral Health -- 3 positions (1 in Juneau and 2 in Anchorage); School Nursing/ School Health/EPSDT - 1 position;
Section Administrative Support --
Administrative Assistant II - 1 position; Office Assistant III - 1 position; Administrative Clerk II - 2 positions; Accounting Technician I - 1 position.

1b. Section of Injury Prevention and Emergency Medical Services:
Alaska Family Violence Project - 2 positions; Child Injury Program - 1 position; Pediatric EMS-1 position.

2. Office of Children's Services: Early Childhood Comprehensive Systems Program - ABCD Screening Academy/Early Childhood Behavioral Health: 1 position; Early Intervention/Infant Learning Program -- 4 positions.

3. Division of Health Care Services: EPSDT program - 2 positions.

4. Division of Behavioral Health: Suicide prevention support: 1 position.

5. Division of Public Assistance: Prevention Services Unit Manager - 1 position; Administrative Support - 2 positions; Community and Family Nutrition Services - 1 position; WIC Nutrition Programs - 10 positions in Anchorage and Juneau. //2010//

E. State Agency Coordination

The Section of Women's, Children's and Family Health (WCFH) intends to carry on the rich and respected collaboration with partner programs within state government, at the federal level, and within Alaskan communities that was the tradition of its predecessor, the Section of Maternal Child and Family Health. WCFH is grounded in the philosophy that strong partnerships and a collaborative approach are critical for systems development, implementation, service delivery and, ultimately, achieving the mission of the Section.

The reorganization of DHSS in 2003, mentioned in previous sections of Part III, created many changes for the Title V program administration, patterns of work, and relationships with other divisions within DHSS during FY 2004. A lot of effort in the ensuing years went into making the organizational transition, orienting and training new staff, and maintaining services while coping with the new environment. Our current effort is focused on re-establishing and strengthening past and existing collaborations, establishing new ones, taking advantage of the program efficiencies that resulted from reorganization, and providing customer satisfaction.

Below is a description of relevant organizational relationships between the Division of Public Health, WCFH, and other DHHS divisions:
1. Office of Children's Services (OCS)-(child protection): The two divisions collaborated together with the Early Comprehensive Childhood Systems (ECCS-HRSA grant). In addition as one of six states awarded the Strengthening Families Initiative grant by the Doris Duke Charitable Foundation, WCFH staff, as representatives of Public Health, will collaborate with the Division of Public Assistance child care licensing personnel, OCS staff, private childcare resource and referral centers and early intervention programs to meet the initiatives outlined by both grants.

/2008/ This last fiscal year, OCS was awarded the ABCD (Assuring Better Child Development) Screening Academy technical assistance awarded by the Commonwealth Fund. WCFH staff will actively participate in this effort closely as the autism screening and diagnosis team gets up and running. //2008//

/2009/The ABCD Developmental Screening Project is a 15 month project that is scheduled to be completed by August 2008. The Core Committee, Stakeholder Group and pilot medical practices will use the data collected in the pilot practices as a foundation for changes in policies and practice and spreading the use of comprehensive developmental screening tool in medical homes.
The project will also provide the vehicle for exploring care coordination and family support needs. As we work with medical practitioners and referral agencies, a model for care coordination will be designed. Because our resources vary greatly in various regions of the state, this will likely be a multi-layered strategy.
Title V staff continue to work closely with the ECCS coordinator in implementing the strategies outlined in the ECCS plan. Specifically Title V staff participate in the subcommittees focused on expanding developmental screening (Goal 1; Objective 5 To develop a model of care coordination to ensure children with developmental or medical needs will be referred to appropriate services) and increasing the eligibility levels to qualify for Denali KidCare (Goal 1;

Objective 6 to increase the number of eligible children enrolled in a public health insurance program). In addition, the perinatal staff participate in early screening using standardized tools for postpartum depression (Goal 1, Objective 10;To increase awareness about the importance of screening for maternal depression and other caregiver mental health issue). The DHSS Children's Policy Team chaired by the acting commissioner oversees much of the planning and implementation for children's behavioral health services. The new Interdepartmental Early Childhood Coordinating Council (IECCC) with a representation from a broader group, will become the body approving revisions to the ECCS and overseeing its progress. The MCH Title V/CSHCN Director sits on both committees. //2009//

/2010/ Title V staff continues to actively participate in activities outlined by the ECCS plan and have a seat at the table on the Interdepartmental Early Childhood Coordinating Council that is tasked to carry out parts of the ECCS plan. Title V staff also participate on the expansion of developmental screening committee (Goal 1; Objective 5 - to develop a model of care coordination to ensure children with developmental or medical needs will be referred to appropriate services) and increasing the eligibility levels to qualify for Denali KidCare (Goal 1; Objective 6 - to increase the number of eligible children enrolled in a public health insurance program). In addition, the perinatal staff participate in early screening using standardized tools for postpartum depression (Goal 1, Objective 10 - To increase awareness about the importance of screening for maternal depression and other caregiver mental health issue). Title V MCH Block grant funding is used in support of implementing the ECCS plan. The Title V MCH Director also sits on the Child Policy Committee. This committee has taken on a different focus under the new leadership of the Assistant Commissioner. At present issues of confidentiality and information sharing policies are under review. The group has been re-organized to manage more child health policy decisions. //2010//.

2. Division of Senior and Disability Services (DSDS): WCFH staff are leading an effort to improve the private sector agencies responsible for coordinated care for medically fragile children discharged from the state's two main NICU's. A steering committee consisting of staff from the Section of Licensing, Office of Children's Services, Medicaid, NICU nurse managers, Durable Medical Equipment providers (DME), early intervention program and others are a part of this quality improvement process.
/2008/ Efforts to streamline processes and open up regulations for more flexible foster parenting models failed to move ahead. The steering committee did identify strategies to improve foster parent recruitment and training for children who are medically fragile. Continued work in this area. //2008//

/2009/ A review of the numbers of children required to stay in the state's two NICU's due to delays in finding medical foster homes indicated a reduced wait for placement in SFY08. Children identified and deemed eligible for the medically complex waiver program were able to find appropriate foster placement with 30-60 days and were successfully discharged. Only one child required a longer waiting period before appropriate foster placement could be found. This is a decrease from the peak of an average of 4-6 children waiting upwards of 9-12 months in 2004-2006. //2009//

3. Divisions of Juvenile Justice, Public Assistance, OCS/Child Protection, and Health Care Services worked with WCFH staff to lead a process of improving the numbers of mandatory reports for statutory rape. An educational workshop developed in part by the Women's Health unit and presented by local law enforcement and child protection personnel was offered to nurse practitioners, school nurses and public health nurses as a pilot. The workshop received very positive reviews and thus more workshops are planned in coordination with community nursing education and public health conferences.

/2009/ Two additional workshops were conducted in rural parts of the state on mandatory

reporting for sexual abuse of a minor. The workshops continue to be well received by the health care providers who participate. //2009//

4. Division of Behavioral Health: WCFH staff has participated in a Comprehensive Mental Health Systems committee to develop strategies to meet the goal of "bringing the children home" from outside behavioral health treatment facilities. Although the focus on prevention of behavioral health issues in very young children is not present currently, this effort has allowed WCFH staff to have an opportunity to insert information regarding the importance of early diagnosis and intervention during the very yearly years as a means to perhaps prevent a need for intervention in the teen years.

5. Federally qualified health centers (FQHC): This program was moved to the commissioner's office at the start of FY05. WCFH staff has worked with them in the past to assist with systems development of infrastructure in some of the more remote communities. WCFH staff has also worked with the FQHC staff on information regarding contraception, immunizations, and care standards for prenatal, neonatal and pediatric patients. Involvement of Medicaid staff with the WCFH staff has resulted in developing a pilot plan to provide payment for case management for adults.

/2008/ The Reproductive Health Partnership has provided training on IUD and Implanon insertion techniques and has provided reproductive products and educational materials in areas of the state where the highest rates of teen and out of wedlock pregnancy exist. In addition, TV and radio PSA's were developed in collaboration with teens from rural and remote parts of the state stressing the importance of healthy relationships and addressing the consequences of relationships where there is a large age difference. This perspective was chosen based on the recommendations from teen focus groups as a means to education and not lecture teens on the particulars of the Sexual Abuse of Minor statutes (statutory rape aspects included) . //2008//

/2009/ The Reproductive Health Partnership continues to provide health care training, supplies and educational materials to health care providers in rural Alaska. A focus on health aid training with the provision of hand outs and teaching methods has been very well received. Staff are now regular presenters at all of the health aide training sessions and their annual conference. Staff partner with public health nursing, juvenile justice center staff, and non-profits run by Alaska Native corporations in supporting not only training but also in the work with teens on health relationships. A trainer from Planned Parenthood was brought up from Outside for a train the trainer sessions in rural Alaska. Additional training opportunities will occur in July with Native Alaskan Teens in preparation for the Youth and Elders conference scheduled for October. //2009//

/2010/ The reproductive health partnership continued to support rural communities identified with elevated teen pregnancy rates through education and long acting contraceptive supplies, although the number of IUD's and Implanon distributed has markedly decreased due to departmental concerns. The focus of teen pregnancy and out of wedlock pregnancy prevention has been on teen education and leadership development this last year. A teen advisory committee is in the process of being formed. New PSA's for radio were taped and will be heard primarily in rural Alaska. //2010//

Division of Public Health: As a Section within the Division of Public Health, WCFH has had daily contact and close working relationships with Public Health Nursing, Chronic Disease Prevention & Health Promotion, Epidemiology, Injury Prevention & Emergency Medical Services (IP/EMS) the Medical Examiner's Office and the Bureau of Vital Records . Each of these sections has supported MCH through data collection and analysis, providing direct health care services, and extending prevention and treatment services for MCH populations. As a result of this work, programs located outside WCFH are including children, those with special needs, and young families.

7. Division of Health Care Services: During the time when several Title V programs resided within the Division of Health Care Services, the Title V/ CSHCN Director established a strong collaboration with the Medicaid staff especially in areas of clinical issues and in the development of regulations that would affect the populations that the MCH programs typically served. For example, regulations around Special Medical Equipment (SME) were updated and staff who manage the programs for CSHCN were instrumental in expanding items to be covered including specialized nipples and bottles for children with Cleft Lips/Palates, digital hearing aids and assistive hearing equipment for newborns and young children are a couple of examples. Clinical staff from WCFH worked with Medicaid on provider billing issues, transportation decisions for CSHCN requiring care at the major pediatric center in Anchorage or outside of Alaska, or for children requiring EPSDT exams. Consultation and management of dental treatments, home health care regulations and payments for CSHCN and pregnant women are additional examples of MCH programs working with Medicaid.
This collaboration continues even as Title V programs were transferred back to the Division of Public Health. As an example, WCFH staff developed a proposal that is awaiting approval to work with Medicaid policy staff to develop a Medicaid state plan amendment regarding the expansion of family planning services.

One goal identified from the Five-Year Needs Assessment is better coordination of programs. One example of fulfilling this goal is the facilitated state leadership workshop titled "EPSDT and Title V Collaboration to Improve Child Health Outcomes" held in May 2006. Participants included staff from the divisions of Public Health, Office of Childrens Services, Health Care Services, Public Assistance, and the Commissioner's Office, and representatives of tribal health agencies. Several new strategies to improving childhood outcomes through the EPSDT program were developed and will be pursued in the coming year. Another example is the on-going collaboration with the Governor's Council on Developmental Disabilities.

A strong collaboration between WCFH and health care providers and agencies has been a priority. WCFH staff are active members of the All Alaska Pediatric Partnership and maintain through this organization contact with health care practitioners, hospitals, clinics and other health care organizations. The Newborn Metabolic and Newborn Hearing Screening programs have also developed strong working relationships with primary care facilities, federally qualified health centers and practitioners throughout the state. Breast and Cervical Health Check, family planning and specialty clinics also promote strong links to community-based service providers in both the private sector and the native health sector.
/2008/ in the coming year, a MCH advisory committee will be established to assist in advising the programs focused on perinatal and birth outcomes, child, and adolescent issues focused on through the Title V national and state performance measures. In addition, a subcommittee for children and adolescents will be formed to address the six specific performance measures for Title V. //2008//

/2009/ The Perinatal committee was created and met for the first time in SFY08, reviewing the work conducted as part of the needs assessment, data and progress made on the performance measures and to identify or validate priorities. A summary of their activities to date can be found in the performance measure section of the MCH Block grant application. //2009//

/2010/ The Perinatal Committee is active in focusing on safe sleep measures in an effort to reduce rollover deaths of neonates-a large contributor to the states post neonatal death rate. In addition, interdivisional planning meetings are looking at a preconception plan focused on healthy pregnancy weights, smoking cessation and reduction of substance abuse in the preconception and intraconception periods. //2010//

At the community level, grantees deliver direct services for WIC, Early Intervention, Breast and Cervical Cancer Screening Outreach, and parent navigation services. WCFH staff has supported community efforts to promote and plan for the health of children and families. WCFH has also provided direct help when significant health problems have occurred in communities with limited

resources. There will continue to be a commitment to service coordination efforts and to addressing new challenges of coordination in the future in light of the reorganization of MCH-related programs and initiatives.
/2008/ The section of WCFH partners with Stone Soup group as a means to meet the outcomes expected as part of the six national performance measures established for children with special health care needs. This organization provides for parent navigation support in a number of different ways including diagnosis specific support on a one to one manner, parents training centers (federal CMS grant), and child specific care coordination processes. Supporting their efforts financially with grants and contracts allows for a greater number of services and systems to be established in the non-profit private sector. //2008//

Other outside partners include the March of Dimes, The Association of Women's Health, Obstetric and Neonatal Nursing, AAP-Alaska chapter, families, and other non-profit organizations, such as Stone Soup, Broken Sparrow, FACE, and the YWCA. Title V funds were utilized to support the development of parent navigation training and expanding this program to communities, in collaboration with the local Family Voices chapter.

Finally, WCFH has a strong relationship with the University of Alaska, both the Anchorage (UAA) and Fairbanks (UAF) campuses. WCFH staff are frequent lecturers in the dental hygiene, human services, nursing, child development, laboratory science and MPH programs. The Section Chief serves on the advisory program for the UAA's MPH program in support of the program's development and future credentialing application. In addition the UAP located at the university is a close collaborator in developing programs for CSHCN especially in the area of transition from adolescents to adulthood.

F. Health Systems Capacity Indicators

Introduction

To follows is the updated report on Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	31.2	33.1	45.5	42.1	33.4
Numerator	91	97	123	111	88
Denominator	29182	29286	27062	26389	26308
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Data Source: Alaska Medicaid. This rate is calculated using Medicaid data.

Notes - 2007

Source: Alaska Medicaid.

Numerator is Medicaid cases from hospitals for children less than 5 years of age with a diagnosis

of asthma (ICD-9: 493-493.92) by state fiscal year (SFY). Denominator is all children under 5 years of age eligible for Medicaid services some time during the SFY reporting period.

Notes - 2006
Source: DHHS, Medicaid files

The numerator is Medicaid cases from hospitals for children less than 5 years of age with a diagnosis of asthma (ICD-9: 493-493.92) by state fiscal year (SFY).

The denominator is all children under 5 years of age eligible for Medicaid services some time during the SFY reporting period.

Narrative:
In FY 2006 the indicator increased by 37% over the previous year. The methodology for measuring the indicator is based on Medicaid records, therefore the indicator is representative of the Medicaid-enrolled population.

The methodology used to calculate this indicator has changed over the years and therefore the rates may not be directly comparable. When rates for 2003 - 2005 are recalculated using the 2006 methodology, we obtain the following results: 2003 - 55.7; 2004 - 33.8; 2005 - 36.5.

In a separate study, the Maternal-Child Health Epidemiology Unit within WCFH analyzed asthma prevalence, exposure and medication use in children using a combination of Medicaid data, the Hospital Discharge database, and data from the Alaska Behavioral Risk Factor Surveillance System. The analysis was published in "Asthma in Alaska: 2006 Report". Additionally, the Division of Public Health and the Anchorage School District collaborated to introduce asthma questions into school health screening forms, although these data have not yet been analyzed. The establishment of capacity to do data analysis has come about as a result of the SSDI grant.

The Alaska Asthma Coalition has implemented public awareness campaigns and worked to achieve successful passage of a bill allowing children to self-administer asthma medications at school. The Division of Public Health sections of WCFH and Chronic disease have been able to conduct some surveillance, but it has been limited. A increment for state general funds in support of an asthma surveillance program was not supported this last fiscal year, however the Alaska Chapter of American Lung Association and the Alaska Chapter of AAFA did receive a one time allotment of capital dollars for SFY06. The utilization of medicaid claims as a result of the SSDI help make analysis of data possible. Access to medicaid claims data is available to any of the MCH Epi staff one they have completed training on the use of the Medicaid claims data base.

/2009/ In FY 2007, the rate of children hospitalized for asthma, among children less than five years old, decreased by 7.4%, to 42.1 per 10,000. //2009//

/2010/ The MCH-Epidemiology Unit continues to build on the extensive research over the last five years which led to improved public health practice. We demonstrated that the most dramatic reductions in asthma hospitalizations occurred among urban Alaska Native children, coincident with an increase in inhaled corticosteroid use. We demonstrated the strong association between particulate matter and asthma in the Anchorage bowl, in response to a recommendation by the US EPA that monitoring of PM10 counts be discontinued because they did not correlate with respiratory outcomes. These results emphasized the local nature of specific components of PM10 and PM2.5 counts and were used to justify continued monitoring of PM10 counts by the Anchorage Municipal Health Department.
(http://www.epi.hss.state.ak.us/mchepi/pubs/misc/AsthmaParticulateEnvironRes_2006.pdf).

The MCH-Epidemiology Unit has applied for a five-year grant from CDC to conduct surveillance and continue epidemiology on asthma. If awared, the grant would be shared with the Section of

Chronic Disease Prevention and Health Promotion.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	83.1	86.6	88.4	86.8	84.2
Numerator	4856	5234	5454	5006	5011
Denominator	5843	6041	6173	5765	5948
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Alaska Medicaid

Notes - 2007
Data source: Division of Health Care Services

Notes - 2006
Source: Division of Health Care Services

Narrative:
/2008/ This measure increased from 86.6% in 2005 to 88.4% in 2006. This is the highest percentage achieved to date.

A facilitated State Leadership Workshop on EPSDT and Title V Collaboration to Improve Child Health Outcomes was convened in May 2006. Participants included representatives from nine state agencies and tribal health organizations. Several strategies were identified and prioritized to follow up in the coming year in an effort to improve the screening rate for children older than 8 years of age and address access to referral providers. In addition, updated newsletters were initiated for families with children less than two years of age. This may have had some effect. The utilization of Medicaid claims as a result of the SSDI, help make analysis of data possible. Access to Medicaid claims data is available to any of the MCH Epi staff once they have completed training on the use of the Medicaid claims database

/2009/ The Division of Health Care Services has not had a program manager for the EPSDT program for over a year, thus the work on outreach has been only a mildly active approach that has included letters of notification to families reminding them of their child's upcoming well-child visit" due date. In addition, processing time of applications for Medicaid through the Division of Public Assistance took on the average 6 months to be completed due to cuts in staffing from the legislature. This has greatly impacted families' ability to get health care as providers are now requiring proof of Medicaid eligibility in hand prior to an appointment being made. Changes in the budget for SFY09 have supporting additional positions to reduce the wait time for application processing. In addition, the Title V/CSHCN program will be adding a position that will focus on EPSDT outreach and school health consultation in SFY09. This position will work collaboratively with the Medicaid program. In addtion, a new position of School Nurse Consultant/EPSDT outreach will be added to the staff in FFY09. This position will provide technical assistance to school districts around the state and those who have school nurses, provide information on

standards of care and disaster planning. In addition, the position will be a liaison for the EPSDT program located in the Division of Health Care Services. It is hoped that outreaching to school age children who are eligible for EPSDT exams will improve the number of children obtaining their well child checks. //2009//

/2010/ In April 2009 the Section of Women's Children's and Family Health implemented a new program, "School Health, School Nursing and EPSDT Promotion", staffed by a nurse consultant. One component of the program will be education and outreach to families eligible for EPSDT. This effort is a continuation of the work intiated in May 2006. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	74.7	76.8	86.5	68.5	68.4
Numerator	65	63	64	61	52
Denominator	87	82	74	89	76
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Alaska Medicaid

Notes - 2007
Data source: Division of Health Care Services

Notes - 2006
Source: Division of Health Care Services

With the reduction in the percentage of FPL for eligibility for the SCHIP program, the number of children qualifying for this program dramatically decreased. Also corresponding with this reduction were the number of women who qualified for the SCHIP program for their pregnancy care.

Narrative:
/2008/ The rate decreased from 76.8% in 2005 to 64.6% in 2006 (numerator=64, denominator=99). With the change in SCHIP eligibility (Title XXI), down to 160% of FPL, fewer children qualified. In addition, it appears more families with children qualified for family Medicaid (Title XIX) which may in part be responsible for the increase in the percentage noted with HSCI #2. This measure is not particularly useful in Alaska because almost all children fall into the category covered by HSCI #2. The children who would be counted under this measure are those whose Medicaid eligibility status changed thereby making them ineligible for Medicaid, a very small number. This data is provided directly from the Medicaid office as part of our ongoing relationships with them. The establishment of capacity to do data analysis has come about as a result of the SSDI grant.

/2009/ The rate for 2006 was incorrectly reported last year as a result of an error in counting the denominator. The corrected 2006 rate is 86.5%. The rate fell in 2007 by over 20%, to 68.5. The

Division of Health Care Services has not had a program manager for the EPSDT program for over a year, thus the work on outreach has been only a mildly active approach that has included letters of notification to families reminding them of their child's upcoming well-child visit" due date. In addition, processing time of applications for Medicaid through the Division of Public Assistance took on the average 6 months to be completed due to cuts in staffing from the legislature. This has greatly impacted families' ability to get health care as providers are now requiring proof of Medicaid eligibility in hand prior to an appointment being made. Changes in the budget for SFY09 have supporting additional positions to reduce the wait time for application processing. In addition, the Title V/CSHCN program will be adding a position that will focus on EPSDT outreach and school health consultation in SFY09. This position will work collaboratively with the Medicaid program.//2009//

/2010/ This measure is not useful for Alaska because almost all children fall into the category covered by HSCI #2. The children who would be counted under this measure are those whose Medicaid eligibility status changed thereby making them ineligible for Medicaid, a very small number. (For reporting year 2008, the numerator = 52, denominator = 76). //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	71.8	72.7	70.0	68.5	
Numerator	6478	7041	7108	6989	
Denominator	9022	9687	10151	10203	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Bureau of Vital Statistics. The latest available data is 2007. This calculation is slightly different than how the true Koteclchuck index is calculated. Missing data is excluded.

Notes - 2007
Source: AK Bureau of Vital Statistics. The latest available data is 2007. This calculation is slightly different than how the true Koteclchuck index is calculated. Missing data is excluded.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

The most recent data available for this indicator is CY2006. CY2007 will be available for the 2010 BG application.

Narrative:
/2008/ The indicator rose slightly from 2004 to 2005, not a statistically significant increase. There has been a gradual but significant decline in this indicator since 1995. Addressing the issue of adequacy of prenatal care and the focus on preconception care will be a primary focus the new perinatal nurse consultant hired this fiscal year. . The perinatal nurse consultant has begun

focused interviews in communities with the greatest number of births to assess access to prenatal care and the community standards and attitudes around early and continuous prenatal care. In October 2006, Dr. Kotelchuck, from Boston University, was a key speaker at the annual Alaska Maternal Infant Mortality Review conference. His recommendations centered around conducting more frequent postpartum/intranatal visits to better assess postpartum depression, take advantage of teaching opportunities with combined postpartum and well baby checks and offer with follow up early contraceptive coverage to improve birth spacing and decrease unintended pregnancies. A pilot program will be designed looking at this model in the coming SFY to be trailed with one of the larger FQHC's where obstetrical and well newborn care is provided.

/2009/ The indicator fell slightly from 2005 to 2006. The perinatal nurse consultant in WCFH organized the first Perinatal Advisory Committee meeting in April, 2008. Strong interest was expressed in the CenteringPregnancy and CenteringParenting programs. It is hoped that these models will be the main topic for the next Advisory Committee meeting. In addition, reports from obstetrical providers to the MCH Title V/CSHCN director indicated their reluctance in in some practices, their policy changed to not accept any obstetrical patients until they had proof of Medicaid coverage. This resulted in many women reportedly not receiving prenatal care until well into their second trimester. Verification of this practice will be looked for in data analyzed from birth certificates and PRAMS reporting. Processing time of applications for Medicaid through the Division of Public Assistance took on the average 6 months to be completed due to cuts in staffing from the legislature. This has greatly impacted families' ability to get health care as providers are now requiring proof of Medicaid eligibility in hand prior to an appointment being made. Changes in the budget for SFY09 have supporting additional positions to reduce the wait time for application processing. //2009//

/2010/ The indicator fell for the second year in a row. According to PRAMS data, for the women who had problems getting early prenatal care during 2004 - 2005, the main reasons given were: 1) could not get an appointment when they wanted one (30%); 2) the doctor or health plan would not start care earlier (26%); and 3) they didn't have enough money or insurance (23%). Of the mothers who delivered a live birth and were surveyed by PRAMS, 48% said that Medicaid was the payment source for prenatal care and 23% used personal income. During this block grant period, the Perinatal Advisory Committee met in October 2008 and May 2009. Agenda topics included a presentation on CenteringPregnancy and CenteringParenting programs, an evidence-based program that emphasizes early prenatal care and support. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	85.5	89.3	89.1	90.3	89.3
Numerator	68734	71571	69398	65144	71468
Denominator	80417	80148	77897	72175	80070
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Source: DHSS, Division of Health Care Services. This indicator is reported on the 1 through 20 age group, and covers the federal fiscal year.

Notes - 2007
Data Source: Division of Health Care Services.

Notes - 2006
Source: DHSS, Division of Health Care Services. Report MR-O-45FFY (Medicaid eligibles); Report MR-O-46FFY (Medicaid recipients).

/2008/ This indicator is reported on the 1 through 20 age group population for FFY 2006.

Narrative:
/2008/ The percent of eligible children receiving Medicaid services dipped slightly from 89.3% to 89.1%. This sustains an upward trend since at least 2000. In May 2006 the state benefited from a State Leadership technical assistance workshop on ESPDT and Title V Collaboration to Improve Child Health Outcomes. One goal identified is to increase the participation rate of eligible children receiving dental services. Another goal is to increase EPSDT visits among older children. Several strategies will be pursued in the coming year. Birthday reminders were instituted for children ages 5 and up to remind parents to follow up with their medical home for an annual physical. In addition, newsletters were updated with rotating health topics that re-emphasized the importance of physical and developmental follow up as well as the types of services covered by Medicaid. Dental utilization has improved with greater access to dentists who are taking Medicaid and the implementation of the dental health aide program in several Alaskan Native villages. The utilization of Medicaid claims as a result of the SSDI grant help make analysis of data possible. Access to Medicaid claims data is available to any of the MCH Epi staff one they have completed training on the use of the Medicaid claims data base.

/2009/The Division of Health Care Services has not had a program manager for the EPSDT program for over a year, thus the work on outreach has been only a mildly active approach that has included letters of notification to families reminding them of their child's upcoming well-child visit" due date. In addition, processing time of applications for Medicaid through the Division of Public Assistance took on the average 6 months to be completed due to cuts in staffing from the legislature. This has greatly impacted families' ability to get health care as providers are now requiring proof of Medicaid eligibility in hand prior to an appointment being made. Changes in the budget for SFY09 have supporting additional positions to reduce the wait time for application processing. In addition, the Title V/CSHCN program will be adding a position that will focus on EPSDT outreach and school health consultation in SFY09. This position will work collaboratively with the Medicaid program.//2009//

/2010/ In April 2009 the Section of Women's Children's and Family Health implemented a new program, "School Health, School Nursing and EPSDT Promotion", staffed by a nurse consultant. One component of the program will be education and outreach to families eligible for EPSDT. This effort is a continuation of the work intiated in May 2006. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	52.0	53.6	53.1	51.6	51.4
Numerator	8732	9110	9000	8376	8324

Denominator	16792	16999	16949	16235	16192
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Alaska Medicaid

Notes - 2007
Data source: Division of Health Care Services

Notes - 2006
Source: Division of Health Care Services

Narrative:
/2008/ The percentage of EPSDT eligible children receiving dental services dipped slightly from 53.6% in 2005 to 53.1% in 2006, not a significant decrease. This is a continuation of a slow but steady upward trend since 1999. Dental services for Medicaid clients is difficult to obtain as many dentists are not accepting new Medicaid clients and the state has only 14 pediatric dental specialists. To fulfill the need for dental services for all people, the Alaska Dental Health Aide Program was developed as a specialty area under the Community Health Aide Program (CHAP) and is operated by Alaska tribal health programs. This program is authorized by federal law only for operation in Alaska. There are four categories of dental health aides, all of whom work under the direct or general supervision of a licensed dentist. The utilization of Medicaid claims as a result of the SSDI grant help make analysis of data possible. Access to Medicaid claims data is available to any of the MCH Epi staff one they have completed training on the use of the Medicaid claims data base.

/2009/ The percentage of EPSDT eligible children receiving dental services decreased slightly from 53.1% in 2006 to 51.6% in 2007. There has been no change in the access to dental services for Medicaid enrolled children, however, the Alaska Dental health Aide Program continues successfully. A new fee structure is anticipated to go into effect for Medicaid services which will increase reimbursements to dentists caring for children and adults needing dental care. //2009//

/2010/ The percentage of EPSDT eligible children receiving dental services remained the same. There has been no change in the access to dental services for Medicaid enrolled children, however, the Alaska Dental health Aide Program continues successfully. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	100	100	100	100	100
Numerator					
Denominator					
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
All State SSI beneficiaries receive rehabilitative services from the State CSHCN program.

Notes - 2007
All State SSI beneficiaries receive rehabilitative services from the State CSHCN program.

Notes - 2006
All State SSI beneficiaries receive rehabilitative services from the State CSHCN program.

Narrative:
In Alaska, all SSI beneficiaries less than 16 years requesting rehabilitative services from the state Medicaid waiver and Developmental Disability waiver programs are eligible for Medicaid. Further, Medicaid covers rehabilitative services for all eligible children (age 0-21) who are SSI beneficiaries. There is no change in status from the previous year.

/2009/ There is no change in eligibility for rehabilitative services from the previous year. In December, 2007, 983 children under age 16 received federally administered SSI payments.//2009//

/2010/ There is no change in eligibility for rehabilitative services from the previous year.//2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	matching data files	6.6	4.7	5.7

An attachment is included in this section.

Narrative:
/2008/ Low Birthweight (LBW) births in the Medicaid population decreased from 7.3% in 2004 to 6.6% in 2005 while increasing 1% in the non-Medicaid population. While the disparity between LBW Medicaid vs. non-Medicaid births in 2005 is at narrowest since 1999, the rise in LBW births in the non-Medicaid population is not a good trend. Analysis of Alaska birth certificate data indicates that from 1989 -- 2003 there was a significant increase in the proportion of moderately preterm (32 to 37 weeks gestation) and no significant change in the proportion of extremely preterm (23 to < 32 weeks gestation) births. Further analysis is needed to determine what the influencing factors are. This information and analysis will be shared with the soon to be formed MCH advisory committee. Participants of this committee will include perinatalogists,

neonatologists, obstetricians and family practice physicians from both rural and urban settings.

/2009/ The proportion of low birth weight births increased slightly among the Medicaid population and decreased among the non-Medicaid population, resulting in a widening of the disparity between Medicaid and non-Medicaid mothers. The Perinatal Advisory Committee expressed strong interest in new prenatal care programs. WCFH will respond by organizing educational meetings around these models. In addition, the MCH-Epi Unit initiated a preterm birth surveillance program centered around analyzing birth certificate data. //2009//

/2010/ A recent evaluation of birth certificate data by MCH-Epidemiology Unit demonstrated that the proportion of preterm births in Alaska is increasing, primarily due to an increase in medical intervention preterm births. Among Alaska Natives, this increase was met with a concurrent decrease in spontaneous preterm births. This may indicate that high risk Alaska Native births are being better monitored. (Summary available at http://www.epi.alaska.gov/bulletins/docs/b2008_12.pdf) A surveillance program that tracks short- and long-term outcomes among all Alaskan preterm births would help evaluate Alaska's capacity to maximize health outcomes. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	7.5	4.9	6.2

An attachment is included in this section.

Narrative:
/2008/ Infant deaths in the Medicaid population decreased from 9.1 to 7.6 per thousand live births. The rate also fell slightly in the non-Medicaid population, thereby decreasing the disparity between the two groups. As noted in prior years, infant mortality rates are tracked in 3- or 5- year moving averages due to the small number of events. Further data analysis is needed to determine what the contributing or influencing factors are regarding this indicator. This information and analysis will be shared with the soon to be formed MCH advisory committee. Participants of this committee will include perinatalogists, neonatologists, obstetricians and family practice physicians from both rural and urban settings.

/2009/ The Maternal and Child Health-Epidemiology Unit has been conducting analysis of the Alaska Maternal-Infant Mortality Review (MIMR) data. A voluntary committee of experts review all infant deaths and form consensus findings on contributors to, and causes of, infant death. For infant deaths occurring between 1992-2001, the committee fully agreed with the death certificate cause of death for 44% of the cases reviewed. The committee found that the three leading cause of death categories reviewed were SIDS/asphyxia, preterm birth, and congenital anomalies. Findings of the MIMR were published and presented by staff. A new medical examiner who joined the state staff has experience and interest in doing more thorough autopsies and investigations of children under the age of one who die in Alaska. New protocols are in the process of being established to support this goal and assure that a correct cause of death is recorded. //2009//

/2010/ The disparity in infant deaths between the Medicaid and non-Medicaid populations

decreased by over 50%, due to a decrease in infant mortality among Medicaid infants and, unfortunately, a slight increase in mortality rates among non-Medicaid infants.

Bed sharing, a common practice in Alaska, is an environment frequently involved in infant death. In 2005, the American Academy of Pediatrics recommended that infants not share a sleep surface with adults or other children. However, analysis of state data by the MCH Epidemiology Unit led to a state policy contrary to national recommendations. The Alaska Division of Public Health recommends that infants may safely bed share if sharing occurs with a nonsmoking, unimpaired caregiver on a standard adult non-water mattress. The Section of Women's Children's and Family Health has implemented a Safe Sleep Initiative to further clarify its recommendations and target public education messages to families engaging in high risk behaviors.

Resources:
"Findings of the Alaska Maternal-Infant Mortality Review 1992 - 2001" report available at http://www.epi.hss.state.ak.us/bulletins/docs/rr2006_03.pdf
"Infant Sleep Position and Co-Sleeping in Alaska" Title V Fact Sheet available at http://www.epi.hss.state.ak.us/mchepi/pubs/facts/fs2005na_v1_17.pdf
//2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	72.5	87.8	80.3

Narrative:
/2008/ The percentage of pregnant women entering care in the first trimester remained approximately the same for both groups. While long term trend has been positive for both groups since 1999, the increase has been larger in the non-Medicaid group. In 2005, the disparity remains about the same, a difference of 14 percentage points.

/2009/ The percentage of women entering care in the first trimester remained approximately the same for both groups, compared to the previous year. //2009//

/2010/ The disparity in the percent of pregnant women entering care in the first trimester between Medicaid and non-Medicaid mothers has remained the same since 2003. About 20% fewer women on Medicaid enter care in the first trimester compared to women not on Medicaid. Among all the women surveyed by PRAMS, problems related to the healthcare system were commonly reported reasons for not getting earlier prenatal care. Nineteen percent of those who reported not getting care as early as desired cited lack of a Medicaid card as a barrier.

"Prenatal Care in Alaska" Title V Fact Sheet available at: http://www.epi.hss.state.ak.us/mchepi/pubs/facts/na/Vol1_Num12.pdf

//2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	67.4	69.5	68.5

Narrative:
/2008/ The percentage of pregnant women with adequate prenatal care (as measured by the Kotelchuck Index) dropped slightly in the non-Medicaid populations by less than 1 percentage point and increased slightly in the Medicaid population by 2.4 percentage points. The disparity between the two groups has been narrowing steadily since 1999.

/2009/ From 2005 to 2006, the percentage of pregnant women with adequate prenatal care (as measured by the Kotelchuck Index) dropped slightly in both groups by about the same amount. //2009//

/2010/ The percentage of pregnant women with adequate prenatal care (as measured by the Kotelchuck Index) continued to drop slightly in both groups, by about the same amount. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	175
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	175

Notes - 2010
Few children in the SCHIP 0 - 1 age range. Only babies who were not born to mothers on Title XIX Medicaid. Babies born to mothers on Medicaid are funded under Title XIX Medicaid for the first year and are reflected in the table below.

Notes - 2010
Few children in the SCHIP 0 - 1 age range. Only babies who were not born to mothers on Title XIX Medicaid. Babies born to mothers on Medicaid are funded under Title XIX Medicaid for the first year and are reflected in the table below.

Narrative:
/2008/ In May 2007 the Alaska Legislature approved legislation that increases the eligibility threshold for Denali KidCare, the state's SCHIP program, to 175% of poverty level and allows for adjustments based on the cost of living. As of early July, the Governor has not yet signed this legislation into law however. In 2003 the income eligibility limits for Denali KidCare were frozen at 175% of that year's federal poverty level. In the ensuing years, inflation reduced the effective eligibility levels and approximately 2,500 beneficiaries lost coverage since 2003. This legislation would reinstate about 1,300 of the beneficiaries who lost coverage. State legislation is pending for consideration during next year's session that would increase the level of eligibility to 200-250% of FPL with buy-in options available.

/2009/ Unfortunately, the Alaska Legislature did not pass the proposal to increase the eligibility level for Denali KidCare. A more coordinated effort pushing changes to eligibility will be organized for the next legislative session. In SF08 legislation did make it through the required committees, but was held in the Rules committee for political reasons and thus did not come to the floor for vote. Several legislators are supportive of increasing eligibility back to at least 200% of poverty this next legislative session. The current administration just recently indicated their willingness to be supportive of this initiative. //2009//

/2010/ Legislation was passed to increase the income eligibility to 175% of the current federal poverty level (as opposed to a poverty level frozen at past years' level). //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 10) (Age range 11 to 14) (Age range 15 to 19)	2008	 175 175 175
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 10) (Age range 11 to 14) (Age range 15 to 19)	2008	 175 175 175

Notes - 2010
Weighted average calculated for year given the three different FPGs that were in effect during FFY 07.

Notes - 2010
Weighted average calculated for year given the three different FPGs that were in effect during FFY 07.

Narrative:
/2008/ In May 2007 the Alaska Legislature approved legislation that increases the eligibility threshold for Denali KidCare, the state's SCHIP program, to 175% of poverty level and allows for adjustments based on the cost of living. As of early July, the Governor has not yet signed this legislation into law however This will reinstate coverage to many of the families that lost coverage since 2003. State legislation is pending for consideration during next year's session that would increase the level of eligibility to 200-250% of FPL with buy-in options available.

/2009/ Unfortunately, the Alaska Legislature did not pass the proposal to increase the eligibility level for Denali KidCare. A more coordinated effort pushing changes to eligibility will be organized for the next legislative session. In SF08 legislation did make it through the required committees, but was held in the Rules committee for political reasons and thus did not come to the floor for vote. Several legislators are supportive of increasing eligibility back to at least 200% of poverty this next legislative session. The current administration just recently indicated their willingness to be supportive of this initiative. //2009//

/2010/ Legislation was passed to increase the income eligibility to 175% of the current federal poverty level (as opposed to a poverty level frozen at past years' level). //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	175

Notes - 2010
Pregnant women are not funded under Title XXI, SCHIP.

Notes - 2010
Pregnant women are not funded under Title XXI, SCHIP.

Narrative:
/2008/ In May 2007 the Alaska Legislature approved legislation that increases the eligibility threshold for Denali KidCare, the state's SCHIP program, to 175% of poverty level and allows for adjustments based on the cost of living. As of early July, the Governor has not yet signed this legislation into law however This will reinstate coverage to many of the families that lost coverage since 2003. State legislation is pending for consideration during next year's session that would increase the level of eligibility to 200-250% of FPL with buy-in options available.

/2009/ Unfortunately, the Alaska Legislature did not pass the proposal to increase the eligibility level for Denali KidCare. A more coordinated effort pushing changes to eligibility will be organized for the next legislative session. In SF08 legislation did make it through the required committees, but was held in the Rules committee for political reasons and thus did not come to the floor for vote. Several legislators are supportive of increasing eligibility back to at least 200% of poverty this next legislative session. The current administration just recently indicated their willingness to be supportive of this initiative. //2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
Alaska's MCH data capacity is very good. There is improved access to Medicaid claims information and Medicaid pharmacy billing data for research and analysis. The Bureau of Vital Statistics is moving towards adopting an electronic birth certificate system, which will enable linkages to the universal newborn hearing screening program and the metabolic screening program in the future. The Hospital Discharge Database continues to improve collection efforts. The SSDI grant has assisted in developing data linkages in support of increasing capacity.

/2009/ The MCH-Epi Unit has utilized WIC data and linked WIC data to birth certificate data. Improvements to usage of WIC data are needed with respect to timeliness of response to data requests and the 'cleanliness' of the data itself. //2009//

/2010/ The State of Alaska is developing a new Medicaid Management Information System that will be effective Summer 2010. This will result in a richer data source, better access to

data, and availability of historic data. WCFH, and especially the MCH Epidemiology Unit, continues to enjoy excellent access to data managed by other state agencies. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
The Youth Risk Behavioral Survey (YRBS) was conducted through a cooperative effort between the Section of Epidemiology and the Alaska Department of Education and Early Development, Division of Teaching and Learning Support. For the 2005 YRBS Alaska obtained a 55% overall response rate, fewer than the CDC requirement of 60%. As a result, no analyses were conducted.

For the implementation of the YRBS in Spring 2007, participating districts were contacted earlier in the academic year for obtaining active parental consent. The minimum overall response rate will be reached for the 2007 school year. Analysis of this data will be forthcoming. There are two bills before the Alaska Legislature that propose changing the consent from active to passive. This change would encourage a higher participation rate in the survey. Currently the bill has passed the House, but his being held in the Senate Rules committee by a legislator who is not in agreement with the change. Further work on exploring how to accommodate his concerns will be investigated during the summer recess.

/2009/ In 2007, the Alaska YRBS obtained an adequate response rate, yielding important survey results on tobacco use and other risk factors. You can find the results of their analysis at http://www.hss.state.ak.us/dph/chronic/school/YRBS.htm.//2009//

/2010/ The 2009 Alaksa YRBS was administered in Spring 2009. The 2009 survey questionnaire is available at http://www.hss.state.ak.us/dph/chronic/school/pubs/2009AKHQuestionnaire.pdf. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Section of Women's, Children's, and Family Health (WCFH) has developed great capacity in terms of programmatic and population-based data analysis and surveillance activities for MCH-related programs. The MCH Epidemiology Unit is key to supporting the MCH Block Grant requirements and the initiatives of the Section. The Unit manages six surveillance programs: Alaska PRAMS, the Childhood Understanding Behaviors Survey (CUBS), MCH Indicators, Surveillance of Child Abuse and Neglect (SCAN), the Birth Defects Registry (ABDR), and the Maternal-Infant Mortality Review-Child Death Review (MIMR/CDR). Their data collection, analysis and research activities provide the basis of accountability required by GPRA as well as reliable data for program evaluation, needs assessments and policy/decision making.

One of our priorities since the 2005 Needs Assessment was to make our data and findings more available to the public.

The Alaska MCH Data Books are intended to serve as a reference guide for statistical and epidemiological information for use in program planning and decision-making. It provides critical data on leading health status indicators and emerging issues in maternal and child health. Four editions have been published -- Health Status edition in 2003, a PRAMS edition in 2005, a Birth Defects Surveillance edition in 2007, and another Health Status edition in 2009. All the data books are available at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/default.htm

The Five-Year Needs Assessment was completed in FY 2006. WCFH used data and findings from the MCH Epi Unit to develop 40 fact sheets on a wide variety of MCH issues. The fact sheets included several assessments: national comparisons; estimates of severity, urgency, disparities and economic loss; interventions and recommendations; and description of capacity to address the issue. They were presented in a series of focus group meetings where needs, priorities and state performance measures were developed. Two new priorities, childhood obesity and mental health, were identified. Three state performance measures were revised, six new measures were developed and one measure remains unchanged. The fact sheets are widely distributed to the media, legislators, other departmental agency staff and members of the public. Condensed, 1-page versions of the fact sheets are planned for the use in the 2010 Needs Assessment planning process. These will include qualitative data on system capacity, strengths, and weaknesses.

CUBS is one of the newest surveillance programs, launched in FY 2006, in response to community and staff concerns on early childhood health. It is a PRAMS follow-up survey that provides population-based data on pre-school aged children in Alaska. The goal is to evaluate the association between prenatal and immediate postnatal factors with early childhood health and welfare. The first year of data collection of two year olds has been completed. The current survey is of three year olds and analysis of the data is underway. Alaska is only one of four states surveying the health and developmental status of toddlers. The positions and expenses associated with this survey are supported with Title V MCH Block grant dollars.

The linkage of PRAMS and CUBS provides opportunities to look at longitudinal data. Both surveys include the same questions about maternal mental health to track state performance measure #10, to increase awareness around mental health issues in the MCH population. In FY 2009 MCH-Epi staff analyzed the prevalence of incident, resolved and persistent symptoms of maternal depression among women who delivered a live-born infant. These results were reported in an Epi Bulletin (available at http://www.epi.hss.state.ak.us/bulletins/docs/b2009_16.pdf). Staff further analyzed risk factors associated symptoms of prolonged maternal depression and the findings were published in the American Journal of Obstetrics and Gynecology. (available at http://www.ajog.org/article/S0002-9378(09)00411-6/abstract).

The PRAMS and CUBS programs are currently working with epidemiologists from the Alaska Native Tribal Health consortium on an MCH databook using PRAMS and CUBS data that will focus Alaska Native and non-Native disparities.

To address the state priority of reducing the rate of child abuse and neglect, a new surveillance program, the Alaska Surveillance of Child Abuse & Neglect (Alaska SCAN) was created in 2007. The program resides within the MCH-Epidemiology Unit. The goal is to provide reliable, accurate, and consistent data of child maltreatment through an integrated and centralized data depository. The Alaska SCAN system links data from various organizations which include, but are not limited to, hospital in-patient records, emergency department records, police and homicide reports, child death review findings, and child protect services reports. This systematic collection of information and application of standardized, sensitive public health definitions promotes data consistency over time. Data from SCAN will also be used to implement, monitor, and evaluate scientifically-based, community focused initiatives, as well as advocate for resources based on reliable and consistent information. MCH-Epi Unit will produce and distribute an annual report describing the findings. Several research papers are being prepared for publication and presentation.

The Alaska MIMR has been instrumental in improving health outcomes of infants since the early 90's. During the fifteen year period from 1990 to 2004, post-neonatal mortality decreased by 37% and neonatal mortality decreased by 32%. The MIMR process is an important contribution to public health practice. It provides an important opportunity for networking and education of providers through participation on the committee. Committee members have a sense of achievement in their work because the MCH Epidemiology Unit has successfully translated the data into positive actions and recommendations. For example, analysis of risk factors associated with SIDS/unexplained asphyxia led to bed-sharing recommendations contrary to those of the American Academy of Pediatrics. The state has implemented a Safe Sleep Initiative to further clarify its recommendations.

To address the state priority of reducing the rate of post-neonatal mortality, the MCH-Epi Unit initiated a preterm birth surveillance project, managed by our CDC CSTE (Council of State and Territorial Epidemiologists) Fellow. Tracking short- and long-term outcomes among all Alaskan preterm births would help evaluate Alaska's capacity to maximize health outcomes of these infants. Initial analysis of birth certificate data was published in an Epi Bulletin.

Analysis of MIMR data in FY 2009 identified additional risk factors for postneonatal mortality among Alaska Native population. The journal article is available at http://www.epi.hss.state.ak.us/mchepi/pubs/misc/MaternalRiskFactors_2008.pdf

The MCH Epi Unit also collaborates with other divisions with DHSS and outside agencies. The unit's pediatric epidemiologist assisted the Anchorage School District to design a School Screening Questionnaire for asthma, evaluated the association between sexual activity related claims and abuse reports among teens enrolled in the Medicaid program and assisted the Healthy Families Intensive Home visitation program in their program evaluation. Finally, he assisted the Section of Epidemiology and the CDC in performing an analysis of invasive neonatal group B streptococcal disease and its relationship to adherence to management guidelines.

An attachment is included in this section.

B. State Priorities

Focus will continue to be on prevention and early intervention services related to family violence, child abuse and neglect, young children's access to health care and reduction of unintended pregnancy. The MCH Epidemiology Unit has primary responsibility to collect and analyze data, and to conduct evaluation and research activities.

State priorities are as follows:
1. Reduce the rate of drug use among families, primarily alcohol intake and cigarette use.

Enabling Services:
- /2008/ New education materials on the effects of smoking and alcohol ingestion have been purchased and will be distributed to health care providers, tribal health centers, FQHC's, and public health centers. //2008//
- /2009/This was a priority issue identified to be focused on in SFY09 by the Perinatal Advisory Committee. Partnership with the Division of Health Care Services (Medicaid) and the Division of Public Assistance will be coordinated in the areas of smoking cessation counseling and public education at public assistance offices. //2009//
- ***/2010/ A new interdivisional preconception/intraconception planning committee has been initiated to focus on improving the health status of women in the adolescent years through preconception, prenatal and postpartum time periods. Specifically, collaborative work is underway on promoting and educating the public on healthy weights, smoking cessation, alcohol and substance abuse prevention and safe sleep practices with newborns. A MCH data book specifically focused on fetal alcohol spectrum disorder is due to be published during this next fiscal year. //2010//***

Population-Based Services:
- WCFH staff collaborates with the local March of Dimes chapters as part of the preterm delivery campaign to develop smoking cessation classes with hospitals and local agencies and to develop support systems for women who are pregnant.

Infrastructure Building Services:
- Alaska PRAMS added questions regarding iq'mik use and commercial spit tobacco use during the prenatal period. These data have never been collected.
- /2009/ Perinatal nurse consultant will partner with Healthy Native Babies Project, working to reduce SIDS and addressing tobacco use. //2009//

2. Reduce the rate of child abuse and neglect.

Enabling Services:
- MCH programs addressing this issue include the Family Violence Prevention Project.
- /2008/ Title V MCH block grant funds support pilot projects at child-care centers across the state who participate in the Strengthening Families Initiative (SFI) focused on enhancing family support. This collaborative effort brings together a leadership team from child welfare, child abuse prevention, early childhood, public health as well as parents and community leaders. //2008//
- /2009/ work continued this last year in the Strengthening Families Initiative. Funding from the MCH Title V Block grant was provided in support of additional pilots and in support of state staff to work on "spread strategies" especially within the child care center and licensed home care facilities. //2009//

Population-Based Services:
- //2008// The Perinatal nurse consultant has completed training on SIDS developed specifically for Alaska native health care providers and pregnant and newly delivered mothers and fathers. She will plan to distribute brochures tailored to the regions of the state she visits as well promote and deliver the training available. //2008//

Infrastructure Building Services:

• WCFH is collaborating with the Office of Children's Services on the Early Care and Comprehensive Systems grant awarded by HRSA.
• /2009/ MCH-Epi Unit established the Alaska Surveillance of Child Abuse and Neglect (SCAN), described in an Epi Bulletin (http://www.epi.alaska.gov/bulletins/docs/b2008_06.pdf).//2009//
• ***/2010/ The Strengthening Families (SF) Leadership Team, which includes the MCH Title V Director, continues to work toward statewide expansion of the model and embedding this framework in state policies and systems. The criteria to become a SF program was finalized and the SF training orientation was standardized. Data collection on practice changes in SF programs continued. The SF Leadership Team is finalizing a Strategic Plan to cover the next three years. //2010//***

3. Increase public awareness and access to health care services for children and CSHCN.

Direct Health Care Services:
• WCFH will continue to sponsor genetics clinics and pediatric specialty clinics that would not otherwise be available in Alaska. ***/2010/ Starting in June 2009, autism screening and neurodevelopmental disorder clinics will be held in 7 additional communities. //2010//***

Enabling Services:
• The EPSDT program distributes age specific newsletters to Medicaid beneficiaries (both Title XIX, and Title XXI) that provide information on new services, the importance of immunizations and regular well child exams, and growth and development norms. EPSDT initiated methods to educate foster parents to improve the level of EPSDT and Medicaid services to children in State custody. ***/2010/ One of the priorities in the child health program will be EPSDT outreach. //2010//***
• /2009/ 2.0 FTE of parent navigation services have been added to the neurodevelopmental center. In addition, a part time parent navigator will be added to the team that travels across the state conducting outreach screening and assessment clinics. Plans are to train and supervise parent navigators in two to three of the larger communities. Parents are also active on the Autism Alliance Ad Hoc committee, the Epilepsy steering committee (coordinated by the Center for Human Development at the University of Alaska-Anchorage), the neurodevelopmental planning committee, all coordinated within WCFH. //2009//
• ***/2010/Parent navigation services are offered for cleft lip/palate clinics, the neurodevelopmental/autism clinics, and the newborn hearing screening program through a contract with Stone Soup Group. Local parents in several communities are available to assist families. Enhancements to the WCFH web site will include a page just for families and youth providing information and links to special education, therapy services, and support services. //2010//***

Population-Based Services:
• The Section Chief of WCFH (the Title V/CSHCN Director) will continue to participate with the All Alaska Pediatric Partnership in the identification of pediatric sub specialists and their recruitment

Infrastructure Building Services:
• The Section Chief of WCFH and program staff work closely with Rural Health program staff responsible for FQHCs to ensure needs of children, pregnant teens and CSHCN are considered in their delivery of services.
• The establishment of newborn hearing screening in all birthing hospitals and centers across the state improved collaboration between early intervention and audiological services. ***/2010/ Hearing screening equipment was purchased and placed in smaller communities, two public health nursing centers with high home/midwifery births. More equipment will be purchased and made available to midwives giving birthing services. //2010//***

4. Reduce the rate of unplanned and unwanted pregnancies including teen pregnancies.

Enabling Services:

- /2008/ Funding provided from the Division of Public Assistance as part of their teen pregnancy and out-of-wedlock pregnancy prevention program paid for training in the placement of IUD's and Implanon, contraceptive supplies and educational materials. The focus of these efforts has been concentrated where the rates of teen and out-of-wedlock pregnancy are the highest: southwest and northern rural communities. //2008//
- /2009/ The Reproductive Partnership focused this year on a train the trainer model for educating teens on healthy relationships and the importance of understanding the "power" in relationships when there is an age discrepancy. Additional public service announcements were created with a visiting trainer/educator to be played in rural Alaskan villages. Contraception education and teen relationships training was provided in rural communities and at the annual Community Health Aide conference. An evaluation component was added to the programmatic efforts to measure outcomes of teen and unintended pregnancies in the communities were the work is concentrated. These same activities will continue in SFY09. //2009//
- ***/2010/ The work outlined for FY2009 will remain the same for the coming year. //2010//***
- Public Health Nursing sites are provided with Title X funding and technical assistance to purchase contraceptives and supplies.
- Title V monies fund three nurse practitioner contracts for family planning services in areas of the state where access is minimal.
- /2009/ The MCH Title V agency provided funding for a women's health nurse practitioner staff member to travel to areas of the state that are in most need of services. The nurse practitioner works one day a week at the Municipality of Anchorage which includes visits to the women's correctional facility. Expansion of these services is being investigated for the next state fiscal year. //2009//

Population-Based Services:

- ***/2010/ As of FY2009, the Title V Abstinence money has been returned to the federal government, there is no intention to reapply due to the required match (3:1). Abstinence education is included in the messages of the reproductive health program. //2010//***
- WCFH staff provides information for medical providers and pubic health professionals on contraception and the need to prevent unintended pregnancies. WCFH staff also offers continuing education opportunities on all topics related to unintended pregnancy.
- WCFH developed a statewide education campaign on teen pregnancy prevention and statutory rape prevention in collaboration with the Division of Public Assistance. Funds will be used to purchase contraceptives such as Mirena and ParaGuard IUD, NuvaRings and emergency contraception for areas of the state where availability is very minimal.

Infrastructure Building Services:

- WCFH staff collaborates with partners on the Alaska Women's Health Partnership to educate the public and medical providers about the need to prevent unintended pregnancies.
- ***/2010/ The newly formed Adolescent Health Program collaborates with the Division of Public Assistance to reduce the rates of teen births in rural areas with a focus on healthy relationships and youth development. Work is accomplished through grants to communities, train the trainer sessions, targeted media campaigns designed with the help of youth, collaborations with a large network of providers and youth, needs assessments, and on-site technical assistance. A youth advisory committee will commence in Fall 2009 to help implement goals. The website is at http://www.hss.state.ak.us/dph/wcfh/adolescent/default.htm //2010//***

5. Increase access to dental health services for children.

Infrastructure Building Services:

- A baseline assessment of 2,300 3rd graders across the state was completed for the State's oral health plan.
- The State's Dental Officer oversees contracts with pediatric dental providers to increase access to services for children enrolled in Medicaid/SCHIP.
- The State's Dental Officer participated in the development of the tribal Dental Health Aide Program and in the development of pediatric resident itinerant rotations in Alaska.
- ***/2010/ The State's Dental Office continues to work with the Alaska Dental Society on workforce development issues in an effort to expand access to dental services in rural Alaska. //2010//***

Enabling Services:
- The Early Periodic Screening Diagnosis and Treatment (EPSDT) program distributes a Medicaid benefits booklet. EPSDT initiated methods to educate foster parents to improve the level of EPSDT and Medicaid services to children in State custody.

6. Reduce the rate of domestic violence.

Enabling Services:
- The MCH addresses these issues primarily through its Family Violence Prevention Project.
- MCH Title V block grant funds a resource center that contains materials on education and prevention of domestic violence.

Infrastructure Building Services:
- PRAMS and CUBS includes questions on domestic violence.
- /2009/The Adolescent Health Manager is an active participate in the CDC's DELTA project-focused on intimate partner and domestic violence. The MCH Title V agency has offered to provide in kind support in the form of evaluation assistance as part of DELTA's application to the RWJ grant focused on Healthy Relationships for preteens and young teens. //2009//
- ***/2010/ The Adolescent Health Manager is actively involved in promoting education around teen dating violence. A teen advisory committee who will collaborate with the Domestic Violence Network in rural and bush locations to decrease teen dating and intimate partner violence. A youth leadership conference is planned this fall. //2010//***

7. Reduce the rate of post-neonatal mortality.

Direct Health Care Services:
- Infants with identified metabolic disorders are referred to state-sponsored Genetics and/or Metabolic Clinics.

Enabling Services:
- Nutrition education information and referral to prenatal care services ensure positive birth outcomes and reduce the incidence of low birth weight among infants born to women enrolled in the WIC Program during their pregnancies.
- WCFH will distributes educational materials: Healthy Mom/Healthy Baby Diaries, a handbook for pregnant women and new mothers, "Never Shake a Baby" and "Back to Sleep" brochures.

Population-Based Services:
- The Newborn Metabolic Screening Program promotes education around reducing the number of hospital discharge refusals and proper collection techniques that has achieved a 100% screening of newborns.
- /2008/ In February 2007, cystic fibrosis screening was added. //2008//

Infrastructure Building Services:
- Data from the Maternal Infant Mortality Review (MIMR) is provided to programs, health

care providers and communities for program planning and education that focus on prevention-related activities such as the Back to Sleep and Never Shake a Baby campaigns. The state has actively engaged all birthing facilities to participate in the national education campaign. ***/2010/ An annual meeting was held earlier in calendar 2009 with community providers who participate in the committee. A list of recommendations was drafted to be included in public health prevention messages and program goals. //2010//***

- ***/2010/ Trends in neonatal mortality are published in Fact sheets and Data Books. Recent research findings by MCH-Epi include: 3 risk maternal risk factors associated with elevated risk of postneonatal mortality among Alaska Native population. (http://www.epi.hss.state.ak.us/mchepi/pubs/misc/MaternalRiskFactors_2008.pdf); and the high prevalence of major congenital anomalies in Alaska (http://www.epi.hss.state.ak.us/bulletins/docs/b2008_16.pdf).***
- ***/2010/ A Safe Sleep coalition has been formed to work on the issues of safe sleep of all Alaska infants. Collaboration with the Indian Health Services is also occurring to tailor the message with sensitivity to the cultural traditions of co-sleeping of the Alaska Native population. The coalition will be meeting in the fall of 2009. //2010//***

8. Reduce the rate of teen suicide.

Infrastructure Building Services:

- WCFH addresses this issue through its adolescent health program, promotion of Youth Developmental Assets, and collaboration with other agencies and organizations. The focus of this work was transferred to the Division of Behavioral Health. The Adolescent Health Coordinator originally in this position was replaced by a Resiliency Coordinator position. This position works to blend in the Assets Model and development of resiliency factors for teens as a means of suicide prevention. Teen suicide prevention is a priority issue in the current administration with a dedicated staff assigned to work on it. Involvement of WCFH staff has been limited.
- //2008// A new Adolescent Health manager started July 1, 2007 with WCFH. A portion of this position and its activities are funded by the MCH Title V Block Grant. //2008//
- Data on teen risk factors is available through the Youth Risk Behavior Survey.
- ***/2010/ The Division of Behavioral Health proposes to create Regional Suicide Prevention Teams in FY 2010. Strategic plans will be developed for each region that will incorporate early prevention, intervention and post intervention strategies to reduce suicide among youth ages 15-24 years of age. Special high risk populations also include Alaska Native male teens, early and pre-teen females, military veterans, gay, lesbian, bi-sexual and transgender (GLBT) youth and youth experiencing institutional or out-of-home residential or mental health treatment settings. In addition, DBH continues to expand the delivery of the Alaska Gatekeeper Suicide Prevention Training curriculum. This year, a Summer Gatekeeper Institute is being planned and will instruct new trainer, provide refresher training and introduce a new youth module to better understand this population including specific risk and protective factors that influence or reduce suicidal behaviors and best practices that can be incorporated into community prevention plans. //2010//***

9. Reduce the prevalence of childhood obesity and overweight.

Infrastructure Building Services:

- Public Health collaborated with the Anchorage School District to conduct an analysis of the prevalence of overweight and obesity among school age children.
- WCFH staff participated in the Healthy Kids Alaska coalition which is focusing on improving the nutritional content of school breakfasts and lunches and is advocating for the removal or change in contents of the vending machines in schools across the state.
- WCFH staff is participating in the Mayor's Task Force on Obesity in Anchorage.
- WCFH continues to collaborate with the Section of Chronic Disease in their activities to assure children's needs are considered in program planning.
- ***/2010/ The new school nurse consultant is collaborating with the Section of***

Chronic Disease on school wellness plans and in shaping materials for schools on obesity prevention. The legislature failed to fund an increment that would have supported more work in this area. Obesity is also a priority for the interdivisional preconception and intraconception planning teams. //2010//.

10. Increase awareness around mental health issues in the MCH population.

Infrastructure Building Services:

- A Future Public Health Summit topic for the Women's Health track will focus on Postpartum Depression and the unique aspects regarding women's mental health issues.
- /2009/ MCH Title V block grant monies assisted in supporting the development and distribution of the postpartum depression packets for providers and for women experiencing postpartum depression.
- The MCH Title V Director participates on the DHSS Commissioner's Child Policy Team which is focused on improving instate access and infrastructure of behavioral health services. In addition, the MCH Title V Director is actively involved on the steering committee and subcommittees for the ECCS grant focused on behavior health training, access and financing strategies. //2009//
- ***/2010/ New analysis was conducted on PRAMS and CUBS surveillance data relating to maternal mental health. Results were published in an Epi Bulletin (http://www.epi.alaska.gov/bulletins/docs/b2009_16.pdf) and will be published in the American Journal of Obstetrics & Gynecology. //2010//***
- The Title V MCH program has continued to financially support the production and distribution of materials on postpartum depression including the HRSA bulletin and support the warm telephone support line. Recent funding cuts at the Children's Hospital at Providence where the program is housed may cause the program to close. Other avenues for funding are being explored. //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98.5	100	100	100	100
Annual Indicator	100.0	92.6	100.0	100.0	100.0
Numerator	10231	25	36	44	195
Denominator	10231	27	36	44	195
Data Source					Alaska Newborn Metabolic Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	100	100	100	100	100

Notes - 2006
Data source: Alaska Newborn Metabolic Screening Program.

In addition, 166 hemoglobin traits were identified but not included in the denominator since no treatment is indicated for these traits. There were also 7 other infants identified with conditions that did not need treatment but which could be important for families and medical providers to know about.

a. Last Year's Accomplishments
The percent of infants screened in the State in CY2008 was 100%. All of the conditions diagnosed through the newborn metabolic screening program are reportable to the Alaska Birth Defects Registry, and the program manager provided the registry with this information on a quarterly basis.

More than 90 confirmed cases of a disorder called carnitine palmitoyl transferase deficiency (CPT-1) are found in the Alaska Native population just this calendar year. All infants to date have been from either western or northern Alaska. The number of confirmed cases of CPT-1 continued to increase and many new projects have been implemented to gain understanding of this deficiency. Biochemical geneticists from Oregon are working with Alaska physicians to try to determine the significance of this new finding. Collaboration with Alaska Native Tribal Health Consortium has been implemented.

All infants identified with sickle cell disease, carnitine defects, amino acid disorders, and congenital adrenal hyperplasia (CAH) in CY 2008 were referred to the genetics and/or metabolic clinics conducted by the State of Alaska (SOA). Parents of children with these disorders needed genetic counseling and advice on their child's disorder.

The program manager continued with educational efforts addressing collection techniques, confirmatory testing requirements, and specimen transport time. These educational presentations often included continuing education credits.

The Newborn Metabolic Screening Advisory Committee (NBMS) held its regular 3 times per year meetings with discussions on CPT-1 lead by physicians on the advisory committee and a presentation from a genetic counselor on referring to genetics clinic following a diagnosis of infant hearing loss. Membership includes hospital laboratory and nursing personnel, general pediatricians and specialists, an ethicist, state program and epidemiology staff.

Activities for work with the Western States & Territories Genetics Collaborative included attending an annual meeting and working on the subcommittee dealing with establishing data points for all of the regional states to collect.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue with education and communication for providers on tandem mass spectrometry disorders		X		X
2. Continue education and monitoring of specimen quality to assure a high level of screening is conducted.		X		X
3. Provide community education through presentations at hospitals, birthing centers, professional organization meetings, and health fairs.				X

4. Refer infants identified with disorders detected through the screening program to State-sponsored Genetics and/or Metabolic clinics.	X			
5. Provide information on reportable conditions to the Alaska Birth Defects Registry on a quarterly basis.			X	X
6. Convene the Newborn Metabolic Screening Advisory committee on a three times per year basis to develop policies and review the program activities.				X
7. Continue to work with the EHDI web-based database vendor to enhance the reporting and searching function of the metabolic integration.				X
8. Initiate a task force to look at issues surrounding CPT-1			X	
9. Continue with active participation on the Western States & Territories Genetic Collaborative grant to improve access and education about genetics services in Alaska.			X	X
10. Continue collaboration with Alaska Native Tribal Health Consortium and Oregon Health & Science University to educate families and medical staff around the state regarding CPT-1 and by distribution of the DVD developed to enhance this process.		X		X

b. Current Activities

Infants identified with CAH, fatty acid oxidation disorders; organic acidemia disorders, biotinidase, and galactosemia are referred to the genetics and/or metabolic clinics conducted by SOA. Infants with hypothyroidism are referred to the Alaska pediatric endocrinology clinic and started on treatment.

Because some infants have false negative tests for CPT-1, a mass educational intervention for providers and families is under way. A CPT-1 deficiency DVD is being distributed to the families and community health aides/practitioners in rural Alaska.

The NBMS Advisory Committee holds meetings three times per year with updates on CPT-1 and discussion of issues such as screening completion, quality control, timeliness of sending samples to the contract lab, diagnostic results and follow-up. The committee is also active in resolving issues such as Medicaid limiting how much specialized formula is sent to families and ethical issues on screening and diagnosis.

Ongoing educational efforts include presentations to physicians, nurses, and hospital laboratorians and professional organizations regarding the screening program, collection techniques, follow-up testing of presumptive positive screens, developing culturally sensitive materials for the Alaska Native population, and the database integration project. Database integration merging newborn hearing screening with metabolic screening into one child health record is in place and being used to track infants and provide reports.

c. Plan for the Coming Year

We anticipate the need for continuing education efforts regarding the lesser-known conditions identified through expanded testing with tandem mass spectrometry. Most important will be education on the confirmatory testing process including proper specimen collection and shipment to the appropriate testing facility. The DVD that was developed for education on CPT-1 deficiency will be widely distributed throughout the state as the scope of the educational effort expands.

Integration of NBMS data with the software database purchased by the Early Hearing Diagnosis and Intervention (EHDI) Program will be completed through all of the phases thus enabling both program managers to run queries and reports. Birthing hospitals will be the first users of the database to have access to the metabolic screening portion of the information with other sites

and providers added over time. This database will provide the means for State program staff to better track infants needing follow-up.

Ongoing work with the Western States & Territories Genetics Collaborative and other children's health programs including EHDI Program, specialty clinics and genetics and birth defects clinics will continue during this next year.

These are enabling and infrastructure-building activities.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	61	63	61	61	61
Annual Indicator	57.2	57.2	57.2	51.8	51.8
Numerator					
Denominator					
Data Source					Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	61	61	61	65	65

Notes - 2008
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments

During 2008, at the State-sponsored genetics clinic, patients met with board certified clinical geneticists for purposes of diagnosis, discussion of the disorder, its history, possible confirmatory testing or carrier testing, and treatment and recurrence risk to future pregnancies. Genetic counseling was non-directive and a genetic counselor was available to families prior to clinic and both during and after the clinic appointment. After meeting with the geneticist, parents were sent a medical report summarizing their genetics clinic visit and laboratory results. Parents were given information about national (disease specific) support groups, local parent contacts, and support organizations. If appropriate, patients were referred to other State specialty clinics for coordination of specialty care. They were given information about Alaska's state CHIP program, Denali KidCare (DKC), and non-State treatment organizations.

The metabolic clinic primarily served children diagnosed with metabolic conditions found through the newborn metabolic screening program as well as newborns with a suspected metabolic disorder. A nutritionist, a board-certified clinical biochemical geneticist, and a genetic counselor worked with parents of children with metabolic conditions (PKU, galactosemia, fatty acid oxidation disorders) to assure dietary compliance and monitor monthly blood tests. The genetic counselor worked with these families to arrange formula shipments and/or assisted families with filing for insurance reimbursements. Further, she assisted families to work with the school district to ensure that their child received special dietary needs, psychosocial assessments, special classroom placement for hearing/vision impaired, modified physical education, or other special education school services.

Pediatric neurodevelopmental screening services were offered in both Fairbanks and in Juneau as screening clinics. A pediatric neurodevelopmental physician saw patients, screened, wrote reports and sent copies to both the family and the family's primary care provider. Parent navigation services were offered at the clinics when available.

In both the metabolic and genetic clinic, a client evaluation form was revised and simplified in an attempt to gather more useful information for program planning, and to increase the response rate. In the past, patient response was about 10-25%. The simplified form is a self-addressed anonymous postcard that asks parents to assess their clinic appointment in terms of the information learned at clinic (understandable, useful, and the information they were looking for), and how the service was delivered. In addition, it asked parents how far they needed to travel to the clinic and how long they had to wait for an appointment after referral. This allowed the staff to re-schedule rural clinics based on population need.

At the cleft lip and palate (CL/P) clinic, parents' received parent navigation services for both treatment and support. The CL/P clinic specifically encouraged parents to become more involved in decision-making through the use of Stone Soup Group parent navigators. Parent navigators in Anchorage and Fairbanks provided clinic preparatory services; during the clinic, observation and note-taking; and as follow-up services, navigation to community service agencies. In addition they delivered information packets to hospitals for distribution to parents of newborns with CL/P. One parent navigator attended the North American Craniofacial Family Conference in Las Vegas. These services and activities were funded through a state grant using MCH block grant dollars.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to hold clinics in public health centers, at the Children's Hospital at Providence, and in clinic spaces easily accessible to parents.	X			
2. Provide patient services for clinics (referrals, scheduling, travel, medical record collection, and follow-up) by public health nurses and clinic coordinator.		X		

3. Update and regularly administer client/family satisfaction surveys for the genetic and metabolic clinics and the CL/P clinics.				X
4. Continue support of parent navigation services with MCH Block Grant funds for CL/P, hearing loss, and for children diagnosed with autism and neurodevelopmental conditions.		X		
5. Disseminate brochures on genetics services consortium to health care providers and parents.		X		
6. Expand parent navigation services to include the new autism screening and evaluation clinics		X		
7. Continue parent involvement on MCH supported advisory committees; recruit parents for new advisory committees for adolescents and perinatal care; finalize a parent advisory group for CSHCN.		X		
8. Continue outreach clinics in current rural Alaskan communities and expand to new communities as financially feasible and needs are identified.	X			
9. Finalize membership of an CSHCN advisory group to serve as a guide for program development with the autism and parent services program.			X	
10. Coordinate with UAA center for Human Development to improve access to care providers as a workforce development effort and include parents in designing curriculum in their training				X

b. Current Activities

Parent navigation services continue for CL/P clinics and for children with a hearing loss. Title V funds parent navigators to travel with providers to clinics to assist families with navigating the system of financing services and making decisions for their children's care. Post-clinic satisfaction surveys for CL/P in FY 09 show that 77% of families who responded felt that services offered at clinics were excellent and family-centered; post clinic surveys for genetic/metabolic clinics revealed that 88% of families thought services were above average or excellent and family-centered.

A newly hired family support program manager, with over 15 years of training and experience in family-centered care and services, manages these travel contracts. She is finalizing the makeup of the parent advisory committee who will review the block grant, provide feedback, and assist with orientation of new staff, advocating for parent participation at many levels. This position also works in collaboration with the Alaska Family Voices.

Parent navigators are an integral member of the Providence Autism Diagnostic Network and The Children's Hospital at Providence Neurodevelopmental Center. They are trained to work with families and assist in decision, making noticeable improvements for families.

A CPT-1 deficiency DVD is being distributed to families and health care providers. The DVD contains information for parents on how best to care for their children and choices they have in their care.

c. Plan for the Coming Year

Ongoing surveys of parents to evaluate needs will continue for the metabolic and genetic clinics. Recognizing the need for a comparable parent satisfaction tool, a survey will be made for families with hearing loss. Collaborating with families through The Children's Hospital at Providence autism center's parent navigators, work groups, and elists will help us expand neurodevelopmental screening services.

Parent navigation services will continue for both CL/P clinics and children with hearing conditions. Parent navigators will work with parents at CL/P Clinics, provide in-service training to hospital staff, and make hospital visits to parents of newborns with orofacial clefts. Parent navigators will visit parents who have a child diagnosed with a hearing loss, assuring that appropriate referrals are made to State-sponsored hearing service providers, early intervention providers, and facilitate parent-to-parent contact. In response to a request from parents, they will determine whether or not it is feasible to organize social activities for cleft-affected teens where they can interact with others who share their diagnosis. One parent navigator and a parent of a cleft-affected child will attend the North American Craniofacial Family Conference in Las Vegas. They will also educate the federally qualified health centers/community health services about their work.

SOA is expanding rural outreach screening clinics to nine sites. Fairbanks and Juneau were the only communities served by screening physicians. Communities being considered include Barrow, Kotzebue, Nome, Dillingham, Bethel, Kenai/Soldotna, Ketchikan, Sitka, Kodiak and Valdez. Contracting with The Children's Hospital at Providence, an advanced nurse practitioner will travel with the Anchorage-based clinic coordinator and a parent navigator will accompany Anchorage-based coordinating staff. The emerging neurodevelopmental clinic expansion incorporates input from parents and providers to serve the highest need efficiently, enhancing parent decision making and autonomy as much as possible. These clinics and the accompanying parent navigator are financially supported by the Title V MCH Block Grant.

Using MCH Title V resources, SOA general funds, and in coordination with a HRSA "Combating Autism" grant, extensive program development and awareness building will be done to increase the numbers of children referred to screening clinics. Collaborative efforts on workforce development with University of Alaska Anchorage Center for Human Development will strive to meet the service needs of children identified on the autism spectrum. Parent navigators who have specialized experiences and training in autism spectrum and other neurodevelopmental disorders are significantly involved in the development of support groups, learning sessions, skill-building sessions for parents and curriculum content for providers.

These activities are infrastructure building, enabling, and direct health care services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	52	54	50	50	45
Annual Indicator	46.5	46.5	46.5	39.3	39.3
Numerator					
Denominator					
Data Source					Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	45	45	45	45

Notes - 2008
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Since the annual indicator for prior years is not comparable to the indicator for the current year. The objective should be revised to reflect the new measurement.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments
Due to geographic location and proportionately small numbers of children, Alaska is uniquely challenged with having adequate providers to meet the traditional definition for a medical home. Children with SHCN receive coordinated and comprehensive medical home care through a combination of pediatricians and family practice physicians, advanced nurse practitioners (ANPs), physician assistant (PAs), public health nurses (PHNs), and community health aides/practitioners (CHA/Ps) in rural and urban areas. We marginally meet the need of subspecialists and continue to contract with Seattle Children's Hospital (SCH) and Oregon Health Sciences University for subspecialty services.

Alaska has one full-time pediatric developmental specialist and access for contracted services for a second pediatrician from Seattle. Efforts to locate a third provider, ANP specifically trained in neurodevelopmental delays, was conducted and eventually successful. Two neurodevelopmental screening clinics were offered in Fairbanks and Juneau. The clinics focused on early identification and screening of children with delays and were then referred to The Children's Hospital at Providence for diagnosis. Referrals to the outreach neurodevelopmental screening clinics came from children's primary health care providers, PHNs, early intervention providers, and Head Start providers. Paper Trails notebooks were given to families of CSHCN to assist in managing medical records.

To meet Alaska's need for a pediatric clinical geneticist, the State of Alaska (SOA) contracted with SCH to conduct statewide outreach clinics. SCH's metabolic geneticists and metabolic nutritionists staffed the metabolic genetics clinic for medical management of children and adults with inherited metabolic conditions, particularly children identified on newborn metabolic screening.

Since there is no craniofacial center in Alaska, the State coordinated clinics for children with facial clefts. A multidisciplinary team of health care providers offered evaluations and treatment planning to families and providers.

Genetic and neurodevelopmental clinics were consultative. Reports were mailed to both the

families and providers that summarized the clinic's evaluation, which may have included recommendations for care and follow up. Geneticists were available to primary physicians for consultation or technical assistance and the genetic counselor worked with local hospitals and SCH to assure that families were referred to appropriate community-based genetics clinics following hospital discharge. The families were aware of and able to attend regional clinics (e.g. metabolic clinics) if a local clinic was not accessible. Finally, the geneticists, genetic counselor, and neurodevelopmental specialist worked with families to locate and refer to out-of-state medical centers for care if instate resources were unavailable.

Patients referred to genetics clinic were required to have the medical home equivalent -- a pediatrician, family practice physician, ANP, PA, or CHA/P's available in the area in which they lived. The genetic counselor or clinic coordinators assisted in finding a medical home if they did not have one.

MCH Block Grant funds and program receipts supported some direct care services for children attending the genetic, metabolic, and neurodevelopmental clinics. No one was refused services due to inability to pay. A sliding fee scale was provided based on poverty guidelines and all third-party payers were accepted.

Continuing education was provided on neurodevelopmental topics to staff at rural public health centers and to local providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand metabolic clinics to other rural locations as needed.	X			
2. Continue financial support with Title V MCH funds for space rental for pediatric neurologist in Fairbanks clinic.		X		
3. Continue parent navigation services (PNS) for parents of children with cleft lip and palate and infants or children identified with hearing loss.		X		
4. Explore and develop a plan for expanding parent navigation services for other specialty conditions in collaboration with medical home.		X		
5. Expand Neurodevelopmental Clinics/Autism screening and assessment clinics to 7 new rural communities.	X			
6. Expand current neurodevelopmental PNS to new outreach and screening clinics		X		
7. Move clinics from public health centers to facilities in the private sector as needed.	X			
8. Educate primary care providers regarding newborn hearing screening regulations and the protocol regarding infants/children identified with hearing loss		X	X	
9. Ensure infants identified with a metabolic disorder on newborn screening receive care from the State sponsored metabolic genetics clinics	X			
10. Collaborate with and educate community providers on new resources available for CSHCN, specifically those affected on the autism spectrum			X	

b. Current Activities

Genetic clinics are held at Alaska Native Medical Center (ANMC). The annual genetics clinic in Bethel saw an increase in participation with only two families unable to travel due to weather.

Cleft lip and palate (CL/P) clinics continue in Anchorage and Fairbanks. Anchorage clinics are held at the ANMC. Title V MCH Block grant funding is used to support these clinics

Primary care providers continue to be educated about the hearing loss protocol. Children with hearing loss are referred to a parent navigator who assists the family in meeting goals regarding early intervention services. Communication with a medical home is key to their work.

The pediatric neurodevelopmental clinic coordinator is working to identify high need areas for clinic expansion. CHA/Ps or itinerant PHNs to report developmental concerns. Parent navigators help families arrange for assistance to travel to Anchorage for comprehensive diagnostic evaluations and assist with navigation of services and funding. They also assure that there is clear and consistent communication back to the primary care provider. Title V MCH Block Grant funding supports these efforts.

Primary care providers are able to refer for all specialty clinics and screening services. If a family self-refers, work is done with the family to identify or locate a medical home for these children. In addition, primary care providers received reports of any EPSDT exams conducted by PHNs in rural health centers.

c. Plan for the Coming Year

Changes to program staff and reassessment of program resources will likely alter the direction of the genetics program in the near future. Eliminating rural clinics and/or replacing them with telemedicine services would be cost saving and time saving (from the clinic standpoint) if it is possible to implement. While Alaska has limited telemedicine capabilities, hospital-to-hospital facilities will improve, and may be utilized to replace in-person clinics, or for in-patient consultations. Following the example of other states, this is likely to begin for patients with established diagnoses, such as follow up for metabolic conditions and for cleft lip/palate. Educating rural physicians on follow up of abnormal newborn screening disorders, especially carnitine palmitoyl transferase deficiency, will allow the primary care provider to assume some of the treatment role. Title V MCH Block Grant funding provides the majority of support for this effort.

The State will continue sponsoring pediatric autism/neurodevelopmental clinics in Fairbanks and Juneau along with pediatric CL/P clinics in Anchorage, Bethel, and Fairbanks. The pediatric neurodevelopmental outreach and autism screening clinics will be expanded to seven regional hubs, based on recommendations from primary care providers in rural hub communities. Additional funding approved by the legislature and funding from the Alaska Mental Health Trust Authority will allow an expansion of neurodevelopmental/autism screening and assessment clinics that will include a traveling parent navigator and clinic coordinator. With all clinics, assuring services are linked with a medical home and are organized in a way that makes sense for families are central to the work conducted.

The State will continue to sponsor genetics clinics in Sitka, Ketchikan, and Juneau in public health centers. The metabolic clinic will continue to hold clinics in Anchorage and Fairbanks and the number of days for the Anchorage clinic will be evaluated to meet the needs of the expanded newborn screening referrals.

These services are direct health care, enabling, population-based and infrastructure building.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	60	60	60	70
Annual Indicator	58.6	58.6	58.6	62.2	62.2
Numerator					
Denominator					
Data Source					Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	70	70	70

Notes - 2008
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments
Insurance information was collected and tracked for all children accessing state-sponsored CSHCN services. CSHCN program collaborated with the Denali KidCare (DKC) program that provides Medicaid coverage to many CSHCN. A contract with the Alaska Native Tribal Health Consortium (ANTHC) provided Indian Health Services (IHS) funds as payer of last resort for genetics and specialty clinics services. TriCare (Dept. of Defense) covered the cost of clinic visits for military dependents referred to State-sponsored clinics. At the cleft lip and palate (CL/P) and neurodevelopmental clinics, more than 59% of children were insured with Medicaid/DKC or IHS funds; more than 50% of children attending the genetics clinics and more than 36% of children attending the metabolic clinic were likewise covered. Less than 2% were self-pay. The balance of children were covered by private insurance or served, regardless of ability to pay, on a sliding scale.

To facilitate access to hearing screening and for follow-up of children born out of hospital, hearing screening equipment was placed in eight public health nursing centers. This allows for hearing screening at no cost for home births, midwifery center births, or infants needing a re-screen

following hospital discharge.

As a result of collaboration with Medicaid, special feeding supplies for CSHCN with facial clefts are now covered.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect and track insurance information for all children accessing state-sponsored CSHCN services.				X
2. Contract with ANTHC to provide IHS funds as payer of last resort for specialty clinics services.	X			
3. Provide genetics and specialty clinics services regardless of ability to pay. Offer reduced fee based on income to families that self-pay.	X			
4. Work with the military on referrals and authorizations to include their beneficiaries in state-sponsored clinics.		X		
5. Bill Medicaid as appropriate for CSHCN who attend state-sponsored specialty clinics.	X			
6. Work with Division of Health Care Services to expand Medicaid coverage for nutritional supplements/foods besides formula for children with inborn metabolic disorders.		X		
7. Continue to work with Medicaid to cover additional formulas for infants identified with metabolic conditions.		X		
8. Continue to provide the Hearing Aid access to enable deaf or hard-of hearing children to obtain hearing aids if their families do not have third-party coverage for them.		X		
9. Work with the Division of Public Assistance to streamline and track their process of application review especially of new pregnant women to assure promptness and assist with acceptance by health care providers.			X	
10. Work with Medicaid staff to track the number of clients falling off Medicaid as a result of requirements enacted from DRA			X	

b. Current Activities

Parent navigation provides essentials services to families attending specialty clinics by helping families secure alternative funding. This year Medicaid/DKC or IHS covered 50 % of children who attended CL/P and neurodevelopmental clinics; 46% of children attending the genetics clinics; and 40% of children attending metabolic clinics. Tricare covered 13% of children seen in the genetics clinics and 16% in metabolic clinics; less than 2% were self-pay with the remaining having private insurance. For CL/P clinics self-pay families were less than 4%, and the remaining families had private insurance. The State and ANTHC signed another contract to provide payment of last resort for ANTHC beneficiaries which can be extended in yearly increments for a total of five years.

Community-based advocacy resulted in improvement in Alaska Medicaid/DKC access. Enrollment regulations were changed to allow 12 months of continuous eligibility for children up to 175% of FPL. Additionally several bills were introduced to change eligibility from 175% to 200% FPL along with co-pays or premiums above 200%, but the legislature ran out of time to complete the legislative process. New advocacy by the Governor's Council on Disabilities and Special Education is underway to add an insurance waiver for children affected by autism, increasing access to funds that will provide intensive early intervention services.

c. Plan for the Coming Year
State-sponsored CSHCN clinic programs will continue collecting data regarding insurance for children who attend the clinics. A referral and TriCare authorization will be requested of military families who attend State-sponsored clinics. However, it is the State of Alaska position that no one is denied services based on their ability to pay.

Parent navigators will continue working with families who attend State-sponsored clinics and families who have an infant diagnosed with a hearing loss, CL/P or has autism or a neurodevelopmental delay and is in need. Parent navigators will assist families with the application process to public insurance programs.

Advocacy continues for a waiver to help families and children on the autism spectrum by the Governor's Council on Disabilities and Special Education. Work with the All Alaska Pediatric Partnership in educating and advocating for expanding eligibility of the DKC program will occur this next legislative session. The Division of Public Health is supportive of these efforts. The Title V MCH Director will work with staff in the Medicaid office to track the numbers of children and pregnant women affected by the requirements for citizenship and birth validation required as a result of the Deficit Reduction Act. Title V staff will also remain alert to evaluating the effects of health reform on medical homes for all women and children as federal legislation is shaped.

These activities are infrastructure building and enabling services.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	75	75	75	75	90
Annual Indicator	73.3	73.3	73.3	85.1	85.1
Numerator					
Denominator					
Data Source					Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Since the annual indicator for prior years is not comparable to the indicator for the current year. The objective should be revised to reflect the new measurement.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments
Due to Alaska's unique challenges in distance and numbers, delivering quality healthcare necessitates creative infrastructure-building and linkages with a broad section of public and private providers. As often the case in other states, service demands typically exceed availability of providers. Services in demand include referrals for specialized medical assessment and/or medical care, psychometric testing for eligibility of special educational services, vision and hearing assessments, and local and national parent support groups for the genetic and neurodevelopmental clinics. Empowered professionals, paraprofessionals and families access information and innovatively found ways to get the needed services.

The genetics and neurodevelopmental clinics were held throughout Alaska in public health clinics or hub regional centers. Extremely rural and remote health care is commonly provided by paraprofessionals known as community health aides/practitioners (CHA/Ps). Public health nurses (PHN's), as itinerant care providers, provide the coordination in cooperation with regional hub-based physicians. Usually PHNs provide clinic services, case management, and technical assistance to families and individuals.

Specific to the genetics clinic, annual reports were reviewed to assess attendance at specific clinic sites and practitioner referral patterns. This was to monitor service delivery and determine if sites were appropriate for changing population needs and access to care. Geneticists provided information, medical consultations and technical assistance to local physicians and health providers via MEDCON, telemedicine, internet resources (http://www.genetests.org), and on-site continuing education presentations at grand rounds. This was particularly useful for providers in rural areas. The genetic clinic manager worked with the newborn metabolic coordinator to ensure that infants with abnormal newborn screening tests were referred to the metabolic genetics clinics for ongoing care as quickly as possible after diagnosis was made. In addition, for our non-English speaking families, professional medically trained interpreters translated the genetics session for the family. Information packets about the genetics condition were provided in their language if possible. Lending libraries of audio-visual and print materials of genetic conditions were available to families. Two state genetics clinics were held at Yukon-Kuskokwim Delta Regional Hospital and Alaska Native Medical Center (ANMC), centers which offer medical care for Alaska Natives. This assured a culturally appropriate service for families, and allows the geneticists to work with the local pediatricians regarding care and follow up recommendations

Pediatric specialty clinics were held in Anchorage, Bethel, Fairbanks, Sitka, Ketchikan, and Juneau so they could be easily accessed by families throughout the state. Providers referred to community-based services as appropriate. Parent navigators who participated in State-sponsored cleft lip and palate (CL/P) and neurodevelopmental clinics provided linkages to services; families who attended clinics were given contact information for providers participating in clinics; and the

clinic coordinator provided information about community-based services. Public health nursing became less involved in directing families to services. However Native health corporations throughout Alaska provided many services to their beneficiaries and offered case management to assure families received care they needed through the regional hub delivery of care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue contracts to deliver genetics and specialty clinics statewide.	X			
2. Assure culturally appropriate services by holding some clinics at Alaska Native medical care facilities.	X			
3. Provide professional medically-trained interpreters to translate the genetics session for non-English speaking families.		X		
4. Provide information packets about genetics conditions in other languages.		X		
5. Expand service delivery by supporting a genetic counselor to based at the Alaska Native Medical Center	X			
6. Continue parent navigation grant to assure families are linked to resources such as support groups, providers and financial aid programs.		X		
7. Offer a venue for health care professionals to get training at specialty clinics and genetics clinics.				X
8. Expand neurodevelopmental clinics/autism screening and assessment clinics to additional rural communities.	X			
9. Develop advisory group that will include all children with SHCN, specifically asthmatics, oncology, CF, and pediatric diabetes				X
10. Collaborate with UAA center for Human Development to expand program options for skill development in neurodevelopmental delays for new employees who can return to their home community and deliver these services.				X

b. Current Activities

The Title V/CSHCN Director and the Children's Health Unit Manager are active participants in the All Alaska Pediatric Partnership, a community coalition of hospitals and medical providers serving the pediatric population of the state. The Partnership recruits pediatric specialists to Alaska. This assists families to access services in state, even if it means them traveling long distances within Alaska.

Specialty clinics program actively builds capacity for specialty services throughout Alaska. Two pediatric dentistry residents attend Anchorage's CL/P clinics as part of their training. A dietician and a speech therapist observe at clinics and shadow a team member in their specialty to learn more about addressing the needs of cleft-affected children.

Two genetic counselors work in Anchorage, one in a private hospital and another in a private perinatology practice. Although neither has had an opportunity to travel to rural areas, they receive many referrals to see patients who live in bush Alaska. The State continues to work with partners to expand genetic and metabolic services to both urban and rural communities.

Parent navigators continue linking families to resources. The specialty clinics program surveys families following CL/P clinic visits. When they are asked if they can easily get services recommended at their clinic visits, 75 percent said it is "easy" or "very easy" to access services.

Alaska Native children are able to receive all of their services at the ANMC.

c. Plan for the Coming Year

The changing roles of PHNs, who act as clinic coordinators for rural clinics, may force the relocation of those clinics and new considerations for care coordination. Other regional medical facilities such as federally qualified health centers will be approached regarding the role in hosting clinics and for financial support.

The Title V program will be work with Stone Soup Group on improved training and coordination of community-specific parent navigators to improve care coordination of community-based services for CSHCN. Parent navigator services will continue at pediatric specialty clinics and for families with infants diagnosed with a hearing loss. Feedback from families confirms their role is helpful in assisting families with services and financing.

The State Title V MCH program continues to be active in the All Alaska Pediatric Partnership which is in the process of conducting a needs assessment and strategic plan to identify and recruit for more pediatric subspecialists. Recent successes include the recruitment of an additional pediatric surgeon, a pediatric hematologist/oncologist, a pediatric advanced nurse practitioner skilled in gastroenterology and one trained in autism and neurodevelopmental conditions. Collaborative efforts are underway to add other subspecialists.

The State is actively looking at expanding the traditional definition of CSHCN to include families outside of the commonly included developmentally delayed (DD) category. Through an advisory committee of parents and providers we expect to expand service delivery to families who have children with chronic conditions such as asthma, cancers, cystic fibrosis, and diabetes. As part of the plan's development, the advisory committee will evaluate national performance measures results, actively participate in the five year needs assessment, and set new goals. Title V MCH Block grant funding is used to support this process.

Title V funds will continue to support CL/P clinics and neurodevelopmental clinics in remote areas of the state where these services are not otherwise available. Additional general funds approved by the legislature plus funding from the Alaska Mental Health Trust Authority will allow neurodevelopmental clinic/autism screening and assessment clinics to expand to more rural communities.

With funds from a separate Combating Autism grant, extensive collaboration is being conducted to determine workforce development needs for early screening and training for intervention services. This group, targeting children with an Autism Spectrum Disorder diagnosis, will improve care delivery across the State. An additional media and outreach committee will raise awareness for the need of earlier interventions.

The State hopes to work with the Alaska Native Medical Center to add an additional genetics counselor who will assist the State-sponsored genetics clinics and provide much needed services for Alaska Native families.

These are infrastructure-building and enabling activities.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	3	1.5	1.5	1.5	50
Annual Indicator	1.1	1.1	1.1	42.2	42.2
Numerator					
Denominator					
Data Source					Child and Adolescent Health Measurement Initiative
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50

Notes - 2008
/2010/ Although this indicator covers age range 0 - 18, the data is defined for children ages 0-17. This is the latest data available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Since the annual indicator for prior years is not comparable to the indicator for the current year. The objective should be revised to reflect the new measurement.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

/2008/ Alaska is using data from the SLAITS CSHCN Survey for this performance measure. There is currently no proxy available, so we are using the most recently reported estimate (2001) for this application. We will update this measure when new SLAITS data are available.

a. Last Year's Accomplishments
Activities from FY07 continue. An annual special education conference offered workshops that include transition specific topics. Customized employment and person-centered planning are highlighted via conferences and workshops.

Creating opportunities for career/job mentoring occurred during Disability Mentoring Day. Youth transition coordinators continued to help youth with disabilities find and keep jobs by helping them gain knowledge and skills needed for employment. They also worked with case managers to ensure housing, transportation, and other issues are addressed. The Division of Vocational Rehabilitation employed a vocational transition coordinator to help youth transition to work or education after high school.

A financial literacy workbook was discussed, yet finding a curriculum that taught youth about finances in order to prevent problems with credit cards and with credit in general proved to be difficult and required a multi-year approach. Guideposts for Success are handed out at a variety of events.

The Governor's Council on Disabilities and Special Education (GCDSE) worked with Stone Soup Group and other PTI's to ensure outreach to parents and youth. Work continued to improve the DD waiver waitlist for youth in transition -- currently some slots are prioritized for youth. In addition, the new Adolescent Health Public Health Specialist in the Section of Women's, Children's and Family Health worked with GCDSE on youth and transition issues as part of the development of adolescent health and healthy relationships training.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue Disability Mentoring Day activities in Fairbanks, Anchorage, Juneau, Kenai, and Sitka.			X	
2. Increase connectivity among local and statewide stakeholders.			X	
3. Continue Intermediaries' work with local organizations to improve outcomes for youth with disabilities.		X		
4. Build the Youth with Barriers in Transition List Serve		X		
5. Increase visibility of youth with disabilities within the larger scope of youth employment.			X	
6. Develop web links for teens and parents of teens to assist in accessing services.		X	X	
7. Work as a technical assistance person for youth and parents when working with systems and providers.			X	
8. Develop a financial literacy curriculum that would be easy to use and distribute it among providers, parents, and teachers.		X	X	
9. Collaborate with the State Commission on Community Service to open up new volunteer opportunities for youth with disabilities.		X	X	
10. Continue the Bring the Kids Home Initiative, ensuring kids with severe emotional disturbance can be served in Alaska instead of being sent out of state and that their transition to adulthood is considered as part of the service delivery.			X	

b. Current Activities

GCDSE built on successes in previous years. The youth liaison continued working to improve communication with youth, parents, and others concerned.

Work continued on the financial literacy component. Combining forces with the Assets Building Group of the Medicaid Infrastructure Grant, the committee was able to find financial literacy curricula to help create a new curriculum specific to Alaskan youth with disabilities or modifying an existing curriculum.

GCDSE also brought the Facing Foster Care in Alaska group to the full council for a discussion about the similarities of populations; foster youth and youth with disabilities are often one in the same youth. GCDSE and the new adolescent health program manager in WCFH worked to ensure youth with disabilities were included in outreach.

Collaboration with partners continued to fund and staff Disability Mentoring Day. GCDSE will

continue to educate businesses and other entities about youth with disabilities and their potential.

The Alaska Statewide Special Education Conference once again offered workshops for special education teachers interested in transition

GCDSE and the Department of Labor and Workforce Development partnered to create the Youth with Barriers in Transition List Serve to increase awareness of opportunities related to housing, scholarships, transportation, and work, etc.

GCDSE is collaborating with the State Commission on Community Service to open up new volunteer opportunities for youth with disabilities.

c. Plan for the Coming Year

GCDSE will continue to network with businesses, state agencies, and providers to improve the lives of youth with disabilities in FY10. Through the Youth with Barriers in Transition List Serve, we will continue to highlight specific opportunities to transition in a holistic manner. That includes highlighting leadership, health, transportation, educational, work, and housing opportunities that are being made available through national, state, and local resources. We will continue to highlight the list serve when doing outreach to rural and urban communities. We plan to grow the list by at least 100 people by the end of FY10.

GCDSE will again be an ardent supporter of the Disability Mentoring Day. We will work with schools and businesses to match youth with appropriate mentors for the day. We hope to have Disability Mentoring Day in more communities this year and will work with local intermediaries and providers to make that possible.

Serve Alaska and GCDSE are working together to make the Americorps, VISTA, and other national service member organizations knowledgeable regarding the benefits of hiring youth with disabilities as part of the program. This is a terrific way for a youth with disabilities to gain skills (job, social, and leadership) as well as contribute to his/her country.

GCDSE will continue to work on the Alaska Statewide Special Education Conference to ensure there is a strong component about transition in the conference and with the Rural Transition Outreach program.

GCDSE is also moving forward on the financial literacy curriculum. Once developed, we will help distribute it to parents, providers, and teachers (both special education and general education).

GCDSE youth liaison will continue to sit on the Alaska Workforce Investment Board's Youth Council. By working with the Youth Council the youth liaison can help influence the policy and procedures followed by Alaska Workforce Investment Act grantees. The adolescent advisory committee will also add youth with disabilities to their membership to assure representation of issues that are meaningful to this population.

These activities are infrastructure-building and population-based services.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	91	85	85.5	86	86.5
Annual Indicator	75.3	75.4	73.5	78.6	
Numerator					
Denominator					
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87	87	87	90	90

Notes - 2008
The most recent data available for this performance measure is 2007. NIS data for 2008 will be available for the 2011 BG submission

Notes - 2007
Source: CDC National Immunization Program, Immunization Coverage in the US, Immunization Survey, NIS Data: Tables, Articles & Figures. (See the 4:3:1:3:3 series). http://www2a.cdc.gov/nip/coverage/nis/nis_iap.asp?fmt=v&rpt=tab03_antigen_state&qtr=Q1/2007-Q4/2007 accessed 3/16/2008.

The most recent data available for this performance measure is 2007. NIS data for 2008 will be available for the 2011 BG submission

Notes - 2006
Data source: National Immunization Survey. The most recent data available for this performance measure is 2006. NIS data for 2007 will be available for the 2010 BG submission

a. Last Year's Accomplishments
The WIC Program screened immunization records for DTaP immunization status and referred children for vaccinations when their records were found to be incomplete. Childcare facilities were audited by Alaska Immunization Program compliance program staff to determine adherence to state statutes for required immunizations and inform State of Alaska Childcare Licensing of compliance status.

The Alaska Immunization Program partnered with Alaska Native Tribal Health Consortium to put on the 2-day 2008 Statewide Maternal Child Health & Immunization Conference. Three tracks targeted all levels of immunization and MCH providers: 1) immunization, 2) pediatrics, and 3) MCH. Keynote speaker was Melinda Wharton MD MPH, CDC Deputy Director of National Center for Immunization & Respiratory Disease.

The Alaska Immunization Program updated the "On Time, Every Time" childhood immunization schedule that indicates the minimum age at which a child should receive a recommended immunization, emphasizing the importance of children receiving their vaccinations at the earliest opportunity.

The Vaccinate Alaska Coalition conducted "I Did It By TWO!" the annual childhood immunization awareness campaign, in conjunction with the Iditarod Trail Committee and the "Race to Vaccinate."

Alaska Immunization Program staff presented immunization information at professional conferences, public and private providers' offices, and to University of Alaska Anchorage School of Nursing nurse practitioner and RN students.

New Advisory Committee on Immunization Practice (ACIP) vaccination recommendations vaccinations were introduced for expanded seasonal influenza recommended age range to include all children age 6 mos through 18 yrs.

FluMist, nasal spray seasonal influenza vaccine, was distributed by the Alaska Immunization Program for the first time during 2008-09. Initially recommended for administration to children age 2 through 4 yrs and later expanded to include children age 2 through 18 yrs.

VacTrAK, the Alaska Immunization Information System, enrolled private & public immunization providers in the testing or development level. Some providers were enrolled in the fully functional production environment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. Screen children enrolled in WIC for DTaP immunization status and refer when needed.			X	
2. Implement childhood immunization schedule.				X
3. Continue to conduct annual immunization awareness campaign, “I Did It By TWO!”			X	
4. Continue to present immunization information and training to a variety of groups.				X
5. . Audit childcare facilities, preschools, and schools for immunization compliance.			X	
6. Implement VacTrAK, the Alaska Immunization Information System.				X
7. Amend the Alaska state regulations on varicella and Tdap.				X
8. Update the Alaska Recommended Childhood & Adolescent Immunization Schedule on influenza.				X
9.				
10.				

b. Current Activities

Governor Sarah Palin accepted an invitation by the Alaska Immunization Program to produce a childhood immunization TV PSA. This PSA is being broadcast throughout the state during 2009.

The Alaska Immumnization Program continues to: provide immunization information and training; audit childcare facilities, preschools, and schools; and support the "I Did It By TWO!" childhood immunization awareness campaign.

VacTrAK, the Alaska Immunization Information System, is enrolling more providers in both the development phase and the fully functional production environment. VacTrAK is a lifespan immunization information system and is designed to include data from all vaccinators, public and private. New VacTrAK IP staff is dedicated to providing technical, training, and managerial support for VacTrAK.

The 2009 Alaska Recommended Childhood & Adolescent Immunization Schedule is updated to include expanded recommendations adopted by the ACIP for universal influenza for children age

6 months to age 18 years. Alaska regulations for childcare and school attendance are implemented for school year 2009/2010.

Alaska becomes a universal-select state and implements CDC required Vaccines for Children (VFC) screening. All recommended childhood vaccines, except meningococcal and HPV vaccines, continue to be available at no cost from birth through 18 yrs. Meningococcal and HPV vaccines are available only to those children who meet at least 1 VFC eligibility requirement:

c. Plan for the Coming Year

Childcare facilities, preschools, and schools will continue to be audited by Alaska Immunization Program staff to assure compliance with Alaska state regulations for required childhood immunizations. Also, the Alaska Immunization Program will continue to provide immunization information and training to various groups.

The 2009 Alaska Recommended Childhood & Adolescent Immunization Schedule will be updated to include any changes to practices recommended and adopted by the ACIP.

The Alaska Immunization Program will provide FluMist, live attenuated seasonal influenza nasal mist vaccine, for 2009-10 and will continue to make it available to children age 2 yrs through 18 yrs.

The Alaska Immunization Program plans to put on a statewide immunization conference in 2010. Many of the MCH Title staff are involved in planning this conference.

The school health nurse consultant will become an active participant in notifing schools of new requirements and work with planned H1N1 vaccination clinics as identified by the Centers of Disease Control and Prevention.

The activities are infrastructure building and population-based services.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	19	19	18	18	18
Annual Indicator	17.7	17.3	18.6	16.0	
Numerator	286	289	315	271	
Denominator	16168	16681	16919	16888	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18	18	18	18	18

Notes - 2008
CY2007 is the most recent data available for this performance measure. CY2008 will be available for the 2011 BG submission.

Notes - 2007
Source: Alaska Bureau of Vital Statistics.

Notes - 2006
Source: Alaska Bureau of Vital Statistics.

CY2006 is the most recent data available for this performance measure. CY2007 will be available for the 2010 BG submission.

a. Last Year's Accomplishments
The birth rate for teens ages 15-17 years in Alaska decreased to an all time low of 16 births per 1,000 teens ages 15-17 years.

Title V continued to fund nurse practitioners to provide comprehensive reproductive health services, including comprehensive education and counseling, at the Kodiak Public Health Center (PHC) and the Juneau High School Teen Health Center, Alaska's only school-based clinic. USPSTF guidelines were strictly adhered to, to assure appropriate, client-centered reproductive health care for women in this program. The WCFH Family Planning Nurse Consultant conducted clinical quality assurance reviews at each site. Service quality exceeded standards set by WCFH.

Although not directly related to prevention/reduction of teen pregnancy, Title V funds also were used for cervical cancer screening services for women of all ages seeking family planning services at all state PHCs in addition to the Kodiak PHC, following USPSTF guidelines. Women with abnormal screening results were referred to the Alaska Breast and Cervical Health Check program for diagnostics and/or treatment as needed.

The WCFH Family Planning Program (FPP) continued to administer the Title X Family Planning Services grant in FY08, offering high quality, low cost family planning and related preventive health services to low income women, men, and teens in communities in the Mat-Su Valley and the lower Kenai Peninsula. FPP Title X services promoted parental involvement in teen decisions to seek family planning services and offered comprehensive sexuality education and counseling, including encouraging abstinence, as a core part of their service delivery.

WCFH continued work under an interdepartmental agreement with the Division of Public Assistance with the goal of reducing teen and non-marital pregnancy in Alaska. Under this agreement (named the Reproductive Health Partnership or RHP), the FPP targeted the problem of sexual abuse of minors by promoting healthy, age-appropriate relationships in Alaska's teens. In November 2007, the RHP sponsored nationally-renowned authority in the area of adolescent sexuality, Bill Taverner, MA, to travel to the rural communities of Nome and Bethel to present interactive workshops on healthy relationships to the following groups: 1) health care professionals, childcare workers, psychologists/counselors, and parents/guardians; 2) groups of youth, including both peer leaders and youth convicted of minor and major crimes; 3) community-wide forums. All participants were given a copy of Mr. Taverner's "Unequal Partners" curriculum. Surveys were conducted to discover: 1) each community's perspective on the health of relationships in their community, and 2) in what forum future educational opportunities on this topic would be best embraced by the community. Surveys from adolescents and adults in both communities showed that all persons were concerned about the quality of relationships in their communities, and that there were local leaders who could assist with efforts to shape healthier communities.

Also under the Division of Public Assistance agreement, a community awareness campaign was developed. Radio and television PSAs were aired statewide, with messages about the

importance of age-appropriate, healthy relationships targeting teen girls younger than 16 and adult males aged 18-22.

RHP activities continued in census areas of the State where rates of births to teens and single women were higher than the State average. Reproductive health educational materials and some long-acting reversible contraceptives were provided at no cost to teens and women of all ages in over 46 Alaskan communities, most of these in remote locations. Skills-based trainings, including hands-on, audio conference, self-study and web-based, were offered throughout the year. Informal surveys of rural health workers were conducted in order to learn perceptions about teens' needs for reproductive health care services. Limited access to comprehensive reproductive health services and high cost of effective contraceptives continued to be the leading concerns.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide funding for nurse practitioners to offer comprehensive reproductive health services at the Kodiak PHC and Juneau High School Teen Health Center.	X			
2. Maintain cervical cytology laboratory contract for all State Public Health Centers.	X			
3. Targeted radio PSAs, recorded by Bill Taverner, air in Nome and Bethel from Jan-Dec 08 to encourage healthy relationships by offering warning signs of unhealthy relationships and tools for making healthy life decisions.			X	
4. Provide fiscal, administrative and clinical oversight to two Title X Family Planning clinics.				X
5. Offer professional educational opportunities on topics relevant to teen reproductive health for health care workers from areas with the highest rates of births to teens.		X	X	
6. Conduct a statewide sexual and reproductive health needs assessment with Alaska youth and their service providers and parents				X
7. Collaborate with other State partners to write, publish and disseminate a white paper on Alaska Youth Sexual Health.				X
8. Provide managerial and technical support to two community partners for a “youth development as a teen pregnancy prevention strategy” grants		X		X
9.				
10.				

b. Current Activities

All FY08 projects are continuing during FY09 with the exception of trainings offered by Bill Taverner. New this year, the Section of WCFH hired an adolescent health program manager (AHPM). She is conducting a comprehensive needs assessment of youth in Alaska and is collaborating with other State of Alaska partners to write, publish and disseminate a white paper on youth sexual health in Alaska.

The AHPM is serving as an active member of a domestic violence and sexual assault prevention steering committee, linking violence prevention and pregnancy prevention for teens. The AHPM has established a wide network of collaborating agencies with which she is consistently collaborating and planning future work.

The AHPM is providing managerial support for two grants to communities entitled "Youth Development as a Teen Pregnancy Prevention Strategy." She is promoting Teen Pregnancy Prevention Month through radio PSAs and a press release

The program manager is participating in the planning of a youth leadership conference entitled Lead On! and is co-planning a reproductive health justice conference focusing on increasing contraceptive access in rural areas for low income women. The Association of Reproductive Health Professionals and RHP are offering seven trainings in reproductive health and contraceptive care counseling in three communities.

c. Plan for the Coming Year

In FY10, Title V will continue to fund nurse practitioners to provide comprehensive reproductive health services at the Kodiak PHC and the Juneau High School Teen Health Center.

Cervical cancer screening services will continue to be funded by Title V and remain available to women seeking family planning services at State PHCs and the Juneau school clinic. Women with abnormal screening results will continue to be referred to the Alaska Breast and Cervical Health Check program for diagnostics and/or treatment as needed.

FPP will continue to administer the Title X Family Planning Services grant serving communities in the Mat-Su Valley and the lower Kenai Peninsula. As required by this federal program, FPP Title X services will continue to promote parental involvement in teen decisions to seek family planning services and to offer comprehensive sexuality education and counseling, including encouraging abstinence, as a core part of their service delivery.

Principals, teachers, teacher's aides, substitute workers, school nurses, and other interested school staff from alternative schools in Anchorage and the Mat Su Valley will be offered training on healthy adolescent relationships and communicating effectively with teens. These staff members are all mandatory reporters of sexual abuse of minors who spend at least six hours each day working with and around at-risk teens. Increasing the knowledge for adults who have so much contact with at-risk youth is a critical need.

The AHPM will continue work started in FY09. In addition, she will present results of the comprehensive needs assessment of youth at the Alaska Public Health Summit. The AHPM will meet with a Youth Health Advisory Committee comprised of all youth, and design programs and campaigns for FY10, including working with youth to create, design and implement a multi media campaign on healthy relationships.

The AHPM will design and coordinate train-the-trainer and adolescent health trainings for youth, teachers, and other service providers on topics such a healthy sexuality, healthy relationships and communication. She will participate in the adaptation of the Fourth R curriculum to make it appropriate for Alaska youth. The Fourth R is a Canadian curriculum which focuses on establishing healthy relationships as a way to reduce substance abuse, violence and teen pregnancy.

The AHPM will participate in a planning session for presenting youth healthy relationships at the Elders and Youth Conference of the Alaska Federation of Natives Convention

Activities for the coming year represent all levels of the MCH pyramid: direct health care, enabling, population-based services, and infrastructure building services.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	24	26	26	26	55
Annual Indicator	14.4	17.5	52.4	52.4	
Numerator	2966	1414	1260	1260	
Denominator	20598	8082	2405	2405	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	55	55	55	55

Notes - 2008
Data source: AK Oral Health Program, 2007 Oral Health Survey. This is survey data.

Notes - 2007
Source: 2004 Oral Health Survey, AK Oral Health Program.

/2008/ The data source has been changed. Previously we estimated this indicator from Medicaid records. We now use data from the AK Oral Health Survey - 2004 conducted by the AK Oral Health Program. Summary report available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/OHAssessment_0405.pdf

Notes - 2006
Source: 2004 Oral Health Survey, AK Oral Health Program.

/2008/ The data source has been changed. Previously we estimated this indicator from Medicaid records. We now use data from the AK Oral Health Survey - 2004 conducted by the AK Oral Health Program. Summary report available at http://www.hss.state.ak.us/dph/wcfh/Oralhealth/docs/OHAssessment_0405.pdf

a. Last Year's Accomplishments
In state fiscal year 2007, the Oral Health Program (OHP) completed the second statewide dental assessment of third grade children using the "Basic Screening Survey" method. The dental assessment process included state baselines on dental sealants on at least one permanent first molar. The state baseline (2007) for sealant utilization in third-grade children was 55.3% (up from 52.4% in 2004); meeting the MCH Block Grant performance measure goal and Healthy People 2010 goal for dental sealant utilization. Sealant utilization for racial/ethnic groups and third-graders reported to be enrolled in Medicaid was as follows:

Dental Sealants Present:

Total (n=813)	55.3% (51.9, 58.7)
American Indian/Alaska Native (n=130)	67.7% (58.9, 75.6)
White (n=442)	56.1% (51.3, 60.8)
All Other (n=241)	50.2% (43.7, 56.7)
Asian (n=63)	47.6% (34.9, 60.6)
Black/African American (n=23)	56.5% (34.5, 76.8)
Hispanic/Latino (n=43)	51.2% (35.5, 66.7)

Native Hawaiian/Pacific Islander (n=19)	31.6% (12.6, 56.6)
Multi-racial (n=93)	53.8% (43.1, 64.2)
Medicaid/Denali KidCare (n=222)	57.2% (50.4, 63.8)
American Indian/Alaska Native (n=56)	66.1% (52.2, 78.2)
White (n=76)	53.9% (42.1, 65.5)
Other (n=90)	54.4% (43.6, 65.0)

Data has not been collected on the number of unduplicated Alaska children aged 8-9 with at least one dental sealant applied to a permanent molar paid for by Medicaid. Sealants not billed to Medicaid are not available; therefore the reported sealant utilization from Medicaid claims with past reports underestimates the sealant utilization in this population. Sealants for children reported as Medicaid eligible remained stable from 57.4% in 2004 (BSS data) to the above noted 57.2% in 2007 (BSS data). Past reports on sealants from Medicaid claims indicated the percentage of children with at least one dental sealant on at least one permanent molar for SFY1997 was 16.7%. For SFY2000-2007 it has varied from a low of 14.4% in SFY2004 to a high of 17.5% in SFY2005. The information from Medicaid claims clearly shows the underreporting from this method as compared with dental assessment information.

This past year the OHP worked with the dental association and University of Alaska to continue training on child abuse and neglect awareness and reporting requirements; implemented Medicaid adult dental preventive and enhanced restorative services (April 1, 2007); sponsored a "CSHCN Oral Health Forum" with development of a strategic plan; provided information to WIC and Head Start on American Dental Association interim guidance on use of fluoridated water with infant formula for infants whose primary food source is formula; and continued work to resume water fluoridation in Juneau.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support and promote community water fluoridation in all communities of Alaska.				X
2. Identify funding to support a statewide dental sealant coordinator.			X	
3. Collaborate with 330 funded Community Health Centers to establish a dental sealant program.			X	
4. Support coalition activities and the implementation of the comprehensive state oral health plan.				X
5. Collaborate with Tribal programs including Head Start and Environmental Health to support dental access, education, sealant application and water fluoridation.				X
6. Maintain program web site for dental access, oral health information and coalition activity.				X
7. Continued technical assistance on information to parents/providers on reducing risks of enamel fluorosis (while still supporting water fluoridation to reduce dental decay).			X	
8. Maintain oral disease burden document describing oral diseases in Alaska and the impact of those diseases on the state.				X
9. Work with Commissioner's Office and Alaska Dental Action Committee for continued implementation of adult dental Medicaid services and report findings to the legislature.				X
10. Work with the Alaska Dental Access Committee to support				X

legislation for increasing scope of practice for dental hygienists.				

b. Current Activities
The Oral Health Program received a 5-year CDC cooperative agreement award to support program infrastructure. The program is working on evaluation plans in relation to the new cooperative agreement. Additionally, the program is supporting a water fluoridation initiative in Seward.

The program assisted in development of parent resource materials for parents/caregivers of CSHCN, worked with Medicaid on a dental reimbursement increase in July 2008 and actively worked supporting the reauthorization of preventative and restorative dental services for Medicaid adults (includes adult pregnant women). The program continues to work with the oral health coalition on implementation of the state plan -- next focus is Medicaid coverage for fluoride varnish application and enhanced dental screening for non-dental EPSDT providers. The program is also working with the Anchorage Neighborhood Health Center and Anchorage school district on a dental sealant pilot project in the 2009/2010 school year.

The Dental Officer and sealant coordinator met with pediatric and Tribal dentists to encourage increase dental visits for children in Medicaid prior to 2 years of age -- this is to address the high levels of early childhood caries and related hospital-based dental treatment seen in Alaska. These activities relate to the program's HRSA MCHB TOHSS grant - goals are to increase age one dental visits, improve oral health and dental access for CSHCN and pregnant women.

c. Plan for the Coming Year
The Oral Health Program is continuing work with Medicaid to address private dental issues with the program to encourage broader dental participation. Other planned activities for FY2010 include: continued work with the Coalition and stakeholders to implement recommendations of the state oral health plan; pilot a school-based/linked dental sealant program; encourage Medicaid to cover fluoride varnish application and enhanced screenings for non-dental EPSDT providers; and continue follow-up training on the "Cavity Free Kids" curriculum for use by Head Start grantee programs. The dental sealant pilot would be in collaboration with a school in a dental-HPSA area and attempt to increase sealants in non-Native racial/ethnic minority students. The program also plans to assist in holding another follow-up meeting to the "CSHCN Oral Health Forum" (held in 2007) -- this meeting will provide updates on progress on the previously developed action plan and prioritizes activities and/or policy development to maintain progress on improving the oral health and dental access for CSHCN.

These activities are direct health care, enabling and infrastructure-building.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	5.8	5.6	5.6	5.6	4.5
Annual Indicator	6.2	6.5	5.0	4.1	
Numerator	28	31	24	20	
Denominator	451114	480546	480464	482503	
Data Source					
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.5	4.5	4.5	4.5	4.5

Notes - 2008
Source: Alaska Bureau of Vital Statistics

The most recent data available for BG FY 2010 is 2005 - 2007. This indicator is reported by 3-year moving averages.

Notes - 2007
Source: Alaska Bureau of Vital Statistics

Notes - 2006
Source: Alaska Bureau of Vital Statistics

The most recent data available for BG FY 2009 is 2004 - 2006. This indicator is reported by 3-year moving averages.

a. Last Year's Accomplishments
Injury Prevention Program (ISPP) continued to maintain and improve collaboration with community-based police, fire, and the medical community, service organizations, Safe Kids and other pro-children groups. ISPP supports the Alaska Child Passenger Safety (CPS) Board, which provides oversight of the statewide program. They met four times during FY 08.

ISPP provided support and CPS training to numerous communities across the state. Through partnering efforts, Anchorage, Fairbanks and Mat-Su became self-supporting for most of their CPS training needs. ISPP led or helped to conduct three CPS Technician certification courses. ISPP held two CPS update/support workshops to assist CPS technicians in renewing their certification

The CPS technician course was made a required as part of the Anchorage Fire Dept (AFD) Academy. ISPP provided support for the first academy class who were cross-trained as CPS technicians. ISPP helped AFD maintain firefighters' certifications by offering continuing education units (CEU) and providing technician assistance. CPS inspections were conducted at each AFD station. ISPP continued to support Southcentral Foundation's CPS training and distribution program by training CPS technicians and technical assistants.

ISPP conducted a CPS introduction course, a public checkup event, and recertification in Ketchikan. In Bethel, ISPP pilot tested the revised beta version of the Safe Native American Program (SNAP) for moving children, coupled with a community checkup event.

ISPP worked with five other CPS instructors from across the nation to revise the SNAP for CPS to fit the new revised standards. The program was piloted and should be ready by close of federal FY09.

The Southeast CPS instructor left and a replacement was not found. Instead, ISPP provided a CPS introductory course and checkup event in conjunction with Juneau Police Department and Southeast Area Regional Health Corporation (SEARHC). ISPP worked closely with the Alaska Office for Highway Safety to provide support for the SEARHC's CPS project.

ISPP developed and gained national approval for a 3 CEU web-based course. CPS technicians require 6 CEUs for recertification. The course was offered twice statewide this year.

ISPP presented at several conferences, including the Anchorage Association for the Education of Young Children and Alaska Family Childcare Association Conference

ISPP continues to work on prevention of traumatic brain injury (TBI) by promoting roadway-bicycle safety awareness and related programs in conjunction with Alaska Native health corporations' wellness camps. ISPP assisted statewide Safe Kids Coalitions and Chapters in the promoting roadway-bicycle safety awareness and the use of helmets and safety activities ISPP worked with the "Safe Routes to School" and "Walk to School" programs and school bus activities within the state. Also, ISPP worked to prevent TBI by evaluating and refining our programs for nontraditional motor vehicle transportation, such as snow machines and ATVs. In conjunction with the TBI Group and the Denali Safety Council ISPP provided $10,000 worth of statewide airtime to encourage helmet use. ISPP has developed a website focused on the prevention of TBI.

ISPP supported CPS technicians and their activities statewide by providing a monthly calendar, putting on our State website of injury prevention activities and training opportunities. ISPP provides support for a statewide Safe Kids Coalition teleconference, a quarterly meeting for CPS instructors.

In FY08 the ISPP provided education in support of legislative action to clearly include booster age children. ISPP was a coordinator/educator in the Booster Seat Coalition. The legislation for the first time passed in the State Senate died in the State House when the 90 day legislative session expired.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Help lead the “Booster Seat Coalition” to support legislation for booster-age children.				X
2. Train firefighters to conduct CSP inspections at each Anchorage FireDepartment and Kenai Fire Department.			X	X
3. Conduct CPS introduction and technician courses.				X
4. Conduct renewal and recertification courses for CPS technicians.				X
5. Revise the “Safe Native American Program (SNAP) for CPS” to fit the new national standards.				X
6. Update and secure national approval for a CEU web-based course.				X
7. Provide boosters, child restraints, and training materials.			X	
8. Promote awareness on the prevention of TBIs through public service announcement.			X	
9. Conduct bicycle rodeo and helmet fitting.			X	
10. Present at instate conferences.				X

b. Current Activities

ISPP continued education efforts to support legislative action to require booster seat use for children. The statute passed the Alaska Legislature and was signed into law this year.

ISPP have led or supported the three CPS technician courses offered this year. ISPP co-led the

renewal course for CPS technicians whose certification had expired.

There is no childhood injury prevention group and few CPS technicians in Juneau. ISPP has worked on site to Juneau providing a CPS introduction course and to provide support to local CPS advocates.

ISPP is working toward a self-sustaining CPS training and programs. Providence Hospital Safe Kids Coalition is working to develop Safe Kids chapters in Ketchikan, Juneau, Homer and Mat-Su. With some financial support these will be viable CPS checkup stations and no longer need significant support from ISPP. ISPP will maintain its support as needed of CPS inspection stations at the community level in other locales.

ISPP has recognized that CPS services to children with special needs are dangerously neglected and have expanded our inventory of CPS restraints for children with special needs. In partnership ISPP will offer the National Health, Transportation and Safety Administration (NHTSA) course on "Safe Travel for All Children" in June. The lead instructor will be Marilyn Bull, the leading pediatrician in this field.

This year ISPP taught and supported the first statewide CPS conference for advocates and technicians.

c. Plan for the Coming Year

ISPP plans to continue to support the Alaska CPS Board that provides oversight of CPS activities and will assist with sponsorship of meetings including at least two face-to-face meetings and two teleconferences.

ISPP will provide support for training but will no longer be the primary statewide coordinator of CPS trainings. However, ISPP will provide CEU-approved trainings to remote and underserved communities such as Nome, Bethel, Sitka, Dillingham, Kodiak and underserved Mat-Su. Also, ISPP will remain the primary CPS training coordinator for state agencies such as Office of Children's Services caseworkers and distribute child and booster seats to those who transport children.

ISPP will continue to strengthen our CPS technician cadre by retaining and increasing the number of CPS technicians and will support all technicians who will need to be using the new CPS certification process. ISPP hopes to again retain over 58% of our present CPS technicians ISPP will provide CPS CEUs for recertification to keep CPS technicians from having their certification expire. Also, they will conduct CPS renewal courses and support to regain those CPS technicians whose certifications have expired.

ISPP plans to continue to promote self-sustaining CPS training and programs. Providence Hospital's Safe Kids Coalition is supporting and developing Safe Kids chapters (with a CPS focus) in Ketchikan and Juneau, as well as previously developed chapters in Homer and Mat-Su. With assistance from all the CPS instructors, the state no longer needs to provide coordination or direct training support for CPS technician training.

ISPP will continue to support CPS technicians and their activities statewide through an email and web-based information distribution system to include, but not limited to, transmission of calendars of injury prevention activities and training opportunities to each CPS technician and instructor. ISPP will maintain and distribute training supplies, child restraints, and DVDs, and will present at instate conferences and workshops.

ISPP will continue work to prevent TBI by evaluating and refining our programs for non-traditional motor vehicle transportation, such as snow machines and ATVs. ISPP is expanding our State

website to increase our material on the prevention of TBI.

ISPP will continue to assist Safe Kids Coalitions and chapters in promoting roadway-bicycle safety awareness and the use of helmets and safety activities. They will support local injury prevention activities such the Bear Paw festival bike rodeo and the Bicycle Summit, including "Safe Routes to School" and "Walk to School" programs and school bus activities within the state.

In response to the new booster seat legislation, we will provide statewide community and law enforcement education and distribution of booster seats and child restraints to underserved communities.

These activities are infrastructure building, enabling, and population-based services.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			60	60	65
Annual Indicator		52.2	14.8	59	53
Numerator		266	1565		
Denominator		510	10605		
Data Source					CDC National Immunization Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	70	70	70

Notes - 2008
/2010/ Source: 2007 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Accessed 3/16/2009 from http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm.

Data is given by child's birth cohort. The latest available data is for children born in 2005, collected from interviews conducted in 2007. Data for the 2005 cohort is provisional, to be updated in 2010. Data for the 2004 cohort is updated.

Notes - 2007
2009/ Source: 2006 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Data is now given by year of birth of the children as opposed to percentage of respondents by year of respondent interview. The latest available data is for children born in 2004, collected from interviews conducted through December 2006. Data for 2004 is provisional, additional updates to 2004 data will be made by NIS in late 2008. For

children born in 2004, some of the survey questions changed.

/2010/ 4. Source: 2007 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Accessed 3/16/2009 from http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm. Data is given by child's birth cohort. The latest available data is for children born in 2005, collected from interviews conducted in 2007. Data for the 2005 cohort is provisional, to be updated in 2010. Data for the 2004 cohort is updated.

Notes - 2006
/2009/ Source: 2006 National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services. Data is now given by year of birth of the children as opposed to percentage of respondents by year of respondent interview. The latest available data is for children born in 2004, collected from interviews conducted through December 2006. Data for 2004 is provisional, additional updates to 2004 data will be made by NIS in late 2008. For children born in 2004, some of the survey questions changed.

a. Last Year's Accomplishments
Alaska WIC's breastfeeding duration at 6 months increased to 51% from the year's previous rate of 49%. WIC received $78,712 to continue the Using Loving Support Breastfeeding Peer Counseling Program. This program was administered initially by the Providence Alaska Medical Center (PAMC) WIC Program and the Armed Services YMCA WIC Program. Within Anchorage WIC Programs were consolidated and the funding shifted to the Municipality of Anchorage and to the Cook Inlet Tribal Council.

A pilot breast pump loan program was initiated with select sites to test an electric single-user-only pump. The pump is ideal for mothers returning to work or school and can be given to rural participants without having to return the pump to the WIC office.

The State WIC Program staff participated on the Alaska Association of WIC Coordinators Breastfeeding Committee and collaborated with the Alaska Breastfeeding Coalition (ABC) in its education initiatives. A panel on innovative breastfeeding practices in hospitals was presented at the 2007 AWHONN conference. Alaska WIC collected data and monitored trends through the Alaska PRAMS and Alaska WIC Management Information System.

The state WIC Breastfeeding Coordinator and Perinatal Nurse Consultant testified at the legislative hearing in support of HB 113, Breastfeeding and Work Place Accommodation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain the Using Loving Support Breastfeeding Peer Counseling Program.			X	
2. Sustain the WIC breast pump loan program and support services for breastfeeding women.		X		
3. Support the Alaska Association of WIC Coordinators Breastfeeding Committee and state agency collaborations.Support the Alaska Association of WIC Coordinators Breastfeeding Committee and state agency collaborations.				X
4. Continue active participation with the Alaska Breastfeeding Coalition.				X
5. Continue data collection and monitoring through PRAMS and Alaska WIC Management Information System.				X

6. Work with partners to plan activities to recognize World Breastfeeding Week in October 2009.				X
7. WCFH perinatal nurse consultant to provide consultation on breastfeeding issues.				X
8.				
9.				
10.				

b. Current Activities
This year Alaska WIC continues receiving funding for the Breastfeeding Peer Counseling Program, implementing it via the Municipality and the Cook Inlet Tribal Council WIC Programs. It also conducts a breast pump loan program and support services for breastfeeding women.

The University of Alaska Anchorage Training Program facilitates a breastfeeding listserv for the statewide support of breastfeeding peer counselors. In addition to the listserv, a monthly newsletter on various breastfeeding topics is sent out. The listserv and newsletter is hosted by an International Board Certified Lactation Consultant.

The University Training Program began the Using Loving Support Breastfeeding Peer Counseling Program as an on-line training so WIC clinic staff or qualified mothers can access the training at any time to become a WIC Breastfeeding Peer Counselor.

The State WIC Breastfeeding Coordinator attended a train-the-trainer program entitled, "The Business Case for Breastfeeding." The training curriculum is intended to assist health care professionals with implementing breastfeeding support in the workplace in their communities.

The State WIC Program staff continues to participate on the Alaska Association of WIC Coordinators Breastfeeding Committee and collaborate with the ABC in its education initiatives. Alaska WIC continues to collect data and monitor trends through the Alaska PRAMS and Alaska WIC Management Information System.

c. Plan for the Coming Year
Next year the WIC Program will continue current year activities to support and promote breastfeeding. Our goal is to maintain or increase initiation and duration rates at 6 and 12 months. More single-user-only pumps will be available statewide to support mothers as they return to work and school. WIC is interested in exploring within the state a breastfeeding workplace policy to support mothers returning to work and maintaining a milk supply. With implementation of the New Food Packages for WIC Clients, the breastfeeding policy will be reviewed and updated to better match the needs of the client to support and promote breastfeeding initiation, duration and exclusivity. The food package will be updated to include fruits, vegetables, and whole grains, while reducing fat and cholesterol. Soy milk and tofu will be available for milk alternatives. Exclusively breastfeeding mothers will have the most expansive food prescription of all WIC clients to help support and promote breastfeeding. The WCFH perinatal nurse consultant will continue to provide consultation, participate in World Breastfeeding Week planning, and testify for the legislature, when requested.

These activities are infrastructure building, population-based, and enabling services.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	60	92	94	96	98
Annual Indicator	87.3	90.5	91.8	92.5	94.6
Numerator	8968	9351	9978	10092	10525
Denominator	10272	10327	10865	10916	11120
Data Source					AK Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
62 infants were not available for screening for one of the following reasons: parental refusal, parental non-response, moved out of state, infant deceased. They were not included in the denominator.

Steady increases are occurring thanks to the active support by the direct entry midwife community in referring families for screening. Hearing screening equipment is availabe in the communites where the majority of home births or birthing center births occurr. Intensive follow up of these families through registered mail and follow up phone calls has also resulted in some families seeking hearing screening for their newborns.

Notes - 2007
Data Source: AK Bureau of Vital Statistics, AK Newborn Hearing Screening Program

Notes - 2006
Source: AK Bureau of Vital Statistics; AK Newborn Hearing Screening Program.

The numerator includes infants who were screened and born in non-hospital settings.

Some birthing facilities were late in reporting data, therefore, the indicator may be revised at a later date.

a. Last Year's Accomplishments
Last year's focus was on implementation of House Bill 109 and the accompanying regulations, which mandated a newborn hearing screening, tracking and intervention program in Alaska, The mandate went in effect January 2008. Relevant information to promote screening and follow-up was distributed to all primary care providers, nurse midwives and direct entry midwives throughout Alaska. A press release was distributed to radio, television and newspapers statewide.

A memorandum of agreement was signed with Early Intervention/Infant Learning Program (EI/ILP) requiring the program to provide names of children diagnosed with hearing loss enrolled in Part C services. The Early Hearing Detection and Intervention (EHDI) Program staff met with

EI/ILP to develop a system for receiving named data that meets HIPAA/FERPA requirements.

A system was developed to communicate with newborn screeners regarding the status of infants in need of follow-up. A status report, exported from the EHDI database, was initiated to fax to all birthing facilities and public health centers on a monthly basis. The report lists infants with a failed or missed newborn screen and screeners are expected to report back to the EHDI Program (by fax) on the status of follow-up efforts. This system reduced the number of infants lost to documentation as well as lost to follow-up. It also identified duplicate data. The EHDI Program manager worked with birthing facilities that had a high rate of missed or failed screens on improving screening procedures and data collection.

To improve data entry by birth screeners, an advanced training on the database was held in May of 2008; twenty-three birth screeners and twelve audiologists were brought to Anchorage for training. Data teleconferences were held quarterly and minutes distributed to all database users. Quarterly practice profile reports were analyzed for data entry, facility refer rate and missed screens. Practice profiles were mailed to providers quarterly and need for improvement communicated.

A system was developed to communicate the need for follow-up with the infant's medical home. The EHDI database was integrated with newborn metabolic screening in January 2008. This provided updated information on the newborn's primary care provider. Certified letters were sent to primary care providers of children who were still noted as "in process" after the fax back reports were reviewed. A process for sending letter to parents regarding the need for a follow-up out-patient screen or referral to audiology was implemented.

A process was established with the Bureau of Vital Statistics and a monthly list of infants born out of hospitals was received. This list was checked monthly against the EHDI database. Certified letters were sent monthly to all parents whose infants were not noted in the database as having a newborn hearing screen. A hearing developmental checklist was developed and was sent to parents along with a screening location card.

The Diagnosis to Intervention Subcommittee met on an ongoing basis to develop a system for diagnosis to intervention services. The group identified areas of need and will work on recommending solutions. The group also drafted an updated version of the EHDI Protocol which will be presented to the Advisory Committee in the future. The committee on progressive/late onset hearing loss met to review the JCIH guidelines for infants with risk factors for hearing loss. In the future, the committee will integrate this population into the EHDI protocol.

In CY08, 10,688 infants received newborn hearing screenings, which is 95% of all occurent births and approximately 98% of all hospital births.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure accurate and complete utilization of the internet based reporting system through ongoing monitoring of data entry and training of new hospital staff, public health nurses, audiologist, early intervention staff and parent navigators.				X
2. Utilize a fax back system with birth screeners to track infants in need of follow-up				X
3. Facilitate meetings of the Diagnosis to Intervention subcommittee to improve the process from diagnosis to intervention services for newly diagnosed children.				X
4. Contact parents of infants born out of hospital regarding			X	X

importance of newborn hearing screening and provide focused education to midwifery centers.				
5. Monitor the data entry by the audiology community in reporting diagnostic information in the database.				X
6. Partner with the Stone Soup Group parent navigators to provide parent-to-parent support and resource information for families of children who are deaf or hard of hearing.		X		
7. Collaborate with the Early Intervention/Infant Learning Program to develop a system for identifying and tracking children with hearing loss.				X
8. Communicate with outlier communities with implemented UNHS and assure adherence to EHDI protocol and linkages to EI, medical home and audiology.				X
9. Partner with AAP Chapter Champion on EHDI presentations to primary care providers.				X
10. Monitor the database for quality assurance and follow-up for children who refer on screening or are diagnosed with hearing loss.				X

b. Current Activities

This year's focus is to increase the number of children tracked successfully through the National 1-3-6 Goals and reduce the number of children lost to follow-up/documentation.

The EHDI Program continues to send monthly fax reports to birthing facilities to improve follow-up. The program is working with pediatric audiology to improve monthly entry of diagnostic data by audiologists as required by the EHDI mandate and facilitate timely access to intervention services.

The EHDI Program is meeting with EI/ILP to implement a process for receiving named data of children with hearing loss enrolled in intervention services. An update on EI/ILP Programs was presented to the EHDI Advisory Committee.

The EHDI communication protocol was updated and finalized by the advisory committee which continues to meet three times a year. The AAP chapter champion presented at pediatric grand rounds highlighting the role of the medical home. The EHDI database was integrated with newborn metabolic screening in January 2008. This provided additional information on the infant's primary care provider.

A team attended the Investing in Family Support Conference in October 2008. A committee of parents continues to meet to address options for connecting with parents of young children with hearing impairments. A parent questionnaire, to be administered by the EHDI Program manager, is in draft form. The EHDI parent navigator is participating in this process.

c. Plan for the Coming Year

Emphasis in the next year will be to increase the State's success in meeting the National 1-3-6 Goals and improve services and supports to young children with hearing loss and their families.

The EHDI Program will analyze the data on infants born out of hospitals and determine which birthing centers/midwives require more education.

The parent survey will be administered and the results analyzed. The parent support committee will continue to meet to explore avenues for improving parent support in the state.

The Diagnosis to Intervention Subcommittee will continue to meet with the goals of identifying

solutions to improving timely referrals to EI/ILP and enhancing the array of supports and services to young children. The parent navigator will participate in this process.

The Late Onset/Progressive Hearing Loss Subcommittee will integrate its recommendations into the EHDI communication protocol.

The AAP chapter champion, along with the EHDI program manager, will provide education to family practice doctors in Anchorage and meet with key stakeholders in Fairbanks.

These activities are infrastructure building, enabling, and population/based services.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	8	14	10	9	8.5
Annual Indicator	11.9	9.2	9.4	11.2	
Numerator	23730	17880	18108	21501	
Denominator	199150	195240	192234	192254	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8.5	8.5	8.5	8.5	8.5

Notes - 2008
2007 is the latest available data.

Notes - 2007
Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2006-2007). Retrieved March 16, 2009 from http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi.

Data covers children 0 - 18 years old. AK Dept. of Labor population estimates would put denominator at 205,460. Estimates (numerator and denominator) based on the Census Bureau's March 2007 and 2008 Current Population Surveys.

Notes - 2006
//2009/ Estimates (numerator and denominator) based on the Census Bureau's March 2006 and 2007 Current Population Surveys. Source: Henry Kaiser Family Foundation, State Health Facts online, Alaska: Health Insurance Coverage of Children 0 - 18, states (2005-2006). Retrieved March 3, 2008 from http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi. Data covers children 0 - 18 years old. AK Dept. of Labor population estimates would put denominator at 205,460.

a. Last Year's Accomplishments
In FFY08, The Alaska Health Care Strategies Council's Final Report: Summary and Recommendations to the Governor included a recommendation to increase the Federal Poverty

Guidelines (FPG) on Denali KidCare (DKC) to 200% FPG - http://www.hss.state.ak.us/hspc/ . As stated last year, the Governor and Department did not make a commitment to support or oppose the legislation to increase the FPGs during the winter 2008 Legislative Session. While the legislation passed out of the Senate and moved through the House Health Education and Social Services Committee, it was never moved to the House Floor for vote from the House Rules Committee.

The Alaska DHSS added six Division of Public Assistance staff members to the DKC Eligibility Office in Anchorage; however, the office did not see a significant recovery in the poverty-level child enrollment that was lost previously due to staff turnover and Medicaid citizenship/identity documentation requirements that began in August 2006. While it appeared that enrollment had improved initially in FFY 08, declines were seen again by the end of the FFY.

As mentioned last year, the Alaska Covering Kids Coalition ceased to exist when the Robert Wood Johnson Foundation grant funding ended. The Department had no Denali KidCare outreach workers, and followed the Title XXI SCHIP State Plan with regard to outreach which included distribution of applications and website maintenance - http://www.hss.state.ak.us/dhcs/denalikidcare/default.htm . The MCH Title V/CSHCN Director was active in Project Access, a program available in Anchorage for individuals who are underinsured or have no insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with staff from WCFH-MCH Title V, Rural Health, Medicaid, Public Health Nursing and the Commissioner's office to work through the challenges in outreach, enrollment and participation for EPSDT in order to meet the Medicaid state plan and				X
2. Respond to requests for information related to Denali KidCare legislation.				X
3. Participate with Regional Tribal Health Centers to conduct administrative activities to ensure efficient and effective administration of the Medicaid enrollment program.				X
4. Work with advocacy groups to encourage action on the part of the legislature to raise the eligibility level for SCHIP to 200% of FPG.				X
5. Title V staff will continue to participate in the redesign and implementation of the new Medicaid Management Information System to assure capacity for new programs, appropriate activities supporting EPSDT, and ease of data tracking for analysis.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The major accomplishment in FFY09 for Medicaid children was the change in regulation to 12-month continuous eligibility. Another program simplification occurred when CMS was notified September 30, 2008 that DHSS plans to end its DKC 1115 Demonstration Waiver on September 30, 2009 related to application of an anti-crowd-out provision or waiting period on low-income

children who have dropped or cancelled coverage within the previous 12-month period and are in families with incomes greater than or equal to 151% FPG. These will be a major program improvements for Alaska.

The Title V program has been very active in promoting the tenets of the Assuring Better Child Development (ABCD) screening program and is working on in collaboration with the Early Childhood Comprehensive Systems (ECCS) program (also located in another division). A joint application for the ABCD III grant will be submitted in support of implementing consistent developmental testing with EPSDT exams.

Title V dollars will continue to provide gap-filling services in the area of pediatric specialties including genetics and metabolic clinics, neurodevelopmental/autism screening services, cleft lip and palate assessment and evaluation, neurology services, and parent navigation. Reproductive health services for young women and teens are also provided using Title V dollars.

There were five bills filed in the FFY 09 legislative session, however none passed both chambers this session.

c. Plan for the Coming Year

Next year, 2010, with the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA) effective April 2009, it is hoped that the Department will continue to reduce the administrative eligibility and enrollment barriers leading to additional program simplifications for children's Medicaid services so that applications, renewals and telephone calls will be processed in a timely manner and the Department has the opportunity to tap the resources available to each state under CHIPRA. Express lane eligibility, another program simplification, is under discussion in Public Assistance which would utilize the eligibility information already collected for other Public Assistance programs to make eligibility determinations. Electronic application, renewal and signature should be reviewed since funding is available under CHIPRA and ARRA to make these programmatic and technological enhancements especially with the My Alaska electronic signature verification process having been implemented several years ago with the application/renewal of the Permanent Fund Dividend. Finally, grant funding is available under CHIPRA for outreach, and should the Department or some other organization in the state apply and be funded, every effort will be made to ensure that enrollment targets are met to comply with the enrollment provisions under CHIPRA to ensure adequate and stable funding for the enrollment of Medicaid eligible and CHIP children so the Department is eligible to receive adequate CHIP allotments, contingency funding if needed and performance bonus payments for enrolling eligible but uninsured low-income children.

It is hoped that the 2nd Session of the 26th Legislature will act on the obvious need of insuring children at a minimum 200% of the FPG to provide coverage for eligible low-income children and will understand that the CHIPRA financing options for enrollment of both Medicaid children and XXI funded children are significantly better than the financing options for SCHIP over the last ten years. It appears that states that opt in early to meet enrollment targets stand to benefit the most considering that rebasing will occur in 2011 and 2013 based on performance.

The MCH Title V/CSHCN Director will focus more attention this next year in working with the Medicaid program (located in another division) and assuring that both programs are more effectively meeting the requirements for outreach and education around EPSDT services and Medicaid coverage. In addition, joint educational sessions will be developed for health care providers around the components of EPSDT and developmental screening in support of the special efforts underway as part of the ABCD program.

These are infrastructure building activities.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			22	21.5	21
Annual Indicator		22.1	21.7	21.6	21.5
Numerator		3787	3398	3371	3374
Denominator		17128	15667	15579	15662
Data Source					WIC program, Report #340.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20.5	20	20	20	20

Notes - 2008
Source: WIC program, Report #340. Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for caucasian children.

Notes - 2007
Source: WIC program, Report #340.

Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. Note that growth curves for Alaska Native children may not be the same as for caucasian children.

Notes - 2006
Source: WIC Program, Report #340

Data covers children 2-4 years, 5 year olds are not included because they are not part of the WIC program. The indicator measures children with a BMI at or above the 95th percentile. AK does not collect data on 85th %-ile. The most recent available data is for 2005. 2006 data will be available for the 2009 BG submission.

Note that growth curves for Alaska Native children may not be the same as for caucasian children.

a. Last Year's Accomplishments
Alaska WIC rates for overweight children decreased from 21.638% to 21.571%. The indicator measured children 2-5 years of age at or above the 95 percentile. The Family Nutrition Programs 2007 Strategic Plan
http://www.hss.state.ak.us/dpa/programs/nutri/downloads/200705_strategicreport.pdf
served as a guide to incorporate an overweight prevention program goal into WIC grantees Requests for Proposals.

Last year sixteen Alaska WIC local agency grantees continued to include the goal to "Reduce the Prevalence of Overweight and Obesity among Alaskan Children and Adolescents," in their Nutrition Education and Services Plans. They implemented "Family Meals and Breastfeeding…So Good For Me," a collaborative effort between WIC, State Nutrition Action Plan and the Alaska Association of WIC Coordinators Nutrition Education Committee. Operational adjustment funds covered Evon Zerbetz' poster artwork matching the "Playtime…. So Good For Me" and the "Water, Water… So Good for Me" nutrition theme poster designs. Operational adjustment funds also supported local agencies to receive 1750 copies of a "Family Meals Cookbook… So Good For Me" for distribution among participants. The goal is to continue to reduce overweight and obesity among Alaska WIC children.

Continued themes for FY08 also included "Playtime So Good For Me," a nutrition education theme, promoting positive family health and wellbeing by encouraging physical activity and child development through unstructured play; and "Water, Water…So Good for Me". Themes are rotated on a quarterly schedule and rounded out by the "Alaska Fruits and Vegetables" theme which is displayed July through September.

"Family Meals and Breastfeeding…So Good For Me," and other nutrition themes are available on the Division of Public Assistance, Family Nutrition Programs, WIC, Nutrition Education website http://www.hss.state.ak.us/dpa/programs/nutri/WIC/WICEducation.htm.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop, improve or adapt nutrition themes: playtime, water, Alaska fruits and veggies, family meals and breastfeeding.			X	X
2. Support grantees in their use of nutrition themes and the distribution of posters, brochures, and activity handouts.			X	X
3. Disseminate nutrition themes via the WIC website, local agencies and State Nutrition Action Plan.			X	
4. Implement and utilize Alaska WIC Nutrition Reports for quality assurance and program planning.				X
5. Identify coordinated objectives to promote healthy eating and active lifestyles.				X
6. Collaborate with the State Nutrition Action Plan (SNAP) group to disseminate nutrition themes				X
7. Incorporate and recommend inclusion of nutrition theme materials into WIC's Nutrition Care Plans				X
8.				
9.				
10.				

b. Current Activities

All projects conducted in the past year were continued in the current year. The goal is to continue to reduce overweight and obesity among Alaska WIC children.

Alaska WIC implemented Nutrition Risk Revision 8 and 9, which include a new WIC dietary assessment approach identifying specific infant, children and women dietary practices and does not count amounts or types of foods eaten.

WIC continues to implement and utilize Alaska WIC Nutrition Reports for quality assurance and program planning and identify coordinated objectives to promote healthy eating and active

lifestyles. It also continues to improve or adapt other nutrition themes, including encouraging increased water intake, selecting Alaska fruits and veggies, supporting family meals and breastfeeding.

In an effort to strengthen collaborations on nutrition education and promotion efforts the State Nutrition Action Plan committee continued to promote healthy eating and active lifestyles through the use of the nutrition education themes. Representatives from six USDA nutrition assistance programs participate in the collaboration: Child Nutrition Programs, Food Stamps Program, Food Stamps Nutrition Education Program, and Food Distribution Program on indian reservations, Family Nutrition Programs, and Cooperative Extension Program.

c. Plan for the Coming Year

Next year Alaska WIC local agency grantees will continue to include the goal to "Reduce the Prevalence of Overweight and Obesity among Alaskan Children and Adolescents," in their Nutrition Education and Services Plans. Local agency grantees will continue to incorporate all nutrition themes in providing their clients' counseling and education.

On October 1, 2009, USDA will start implementing the New Food Packages for WIC Clients. These new food packages, tailored for each client profile including pregnant, breastfeeding, and postpartum women, breastfeeding and formula-fed infants, and children ages 1-5, will align the Food Packages to the 2005 Dietary Guidelines for Americans and the infant feeding recommendations of the American Academy of Pediatrics. The Dietary Guidelines for Americans encourage combining physical activity with good choices from every food group. It emphasizes fruits, vegetables, whole grains, and fat-free or lower fat dairy products for children over age 2 and adults. It also encourages lean meats, poultry, fish, eggs, and nuts, as well.

The New Food Package is designed to be cost neutral even with the incorporation of fruits and vegetables, fresh, frozen or canned. Soy milk and tofu will be available as milk alternatives. Whole grains such as cereals, breads, and other products will also be added. Milk, eggs, and juice will be reduced. These changes will help families to consume more nutritious meals for their families using WIC foods. The Alaska WIC program has established an advisory council to plan the implementation of these great changes, which can help lower the child obesity rate in Alaska. WCFH will partner with WIC to help disseminate the new guidelines, especially related to perinatal women and infants, and will include guidelines in revision of the Healthy Mother, Healthy Baby Diary.

The current WIC computer system is slated for replacement July 2010. The new system will continue to capture data on overweight and will lend itself to more flexible reporting functionality. This will assist the Alaska WIC program in planning and assessing efforts to address overweight in our state. This coming year will be focused on hiring a contract who will transfer a new WIC computer system while making changes to the program to meet Alaska's needs. Complete implementation will be in January 2011.

These activities are infrastructure building, population-based, enabling, and direct health care services.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective			15	15	13.5
Annual Indicator		16.7	14.8	15.5	
Numerator		1602	1565	1645	
Denominator		9581	10605	10613	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13.5	13.5	13.5	15	15

Notes - 2008
Source: Alaska PRAMS

The latest data available is for CY 2007.

Notes - 2007
Source: Alaska PRAMS

The latest data available is for CY 2007.

Notes - 2006
Source: Alaska PRAMS

The latest data available is for CY 2006. 2007 data will be available for the 2010 BG submission.

a. Last Year's Accomplishments
The perinatal nurse continued to meet with public and private health care providers and administrators at facilities across Alaska to assess perinatal health needs (including tobacco-related needs), collaborate on program development, and evaluate efforts. She visited the bush towns of Nome and Kotzebue, where tobacco use during the last 3 months of pregnancy is especially high. In Anchorage, she held the first perinatal advisory committee meeting, attended by 32 health care providers representing a variety of geographic areas, types of facilities, and health care professions. Members expressed interest in tobacco cessation efforts. WCFH participated in a project to support the city health department in a MCH indicator project

The WCFH Epidemiology Unit continued to conduct MCH outcome data analyses and update MCH publications. WCFH Epi Unit and state tobacco program collaborated on an in-depth analysis of BRFSS and PRAMS data related to tobacco cessation.

Our Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health have been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care, tobacco cessation booklets, and other materials furnished through Title V funding were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

In October 2007, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) to conduct a conference. The perinatal nurse consultant coordinated a perinatal track at the Alaska Health Summit conference December 2007. Both conferences included a session on tobacco cessation. Also, a perinatal list serve was started that

has been used to share information about evidence-based programs and professional education opportunities.

Progress continued on the tobacco treatment database project, which expanded to a total of 9 grantees. In November Free and Clear took over The Alaska Quit Line contract from Providence. They have implemented a more intensive, new pregnant caller program. The perinatal nurse consultant promoted the Alaska.

A method of billing for smoking cessation counseling and medications was established in FY06 for Medicaid patients who are pregnant and those under 21 years of age. Medicaid providers who are physicians, nurse practitioners, and community health aides may bill for these services. The Medicaid workgroup of Alaska Tobacco Control Alliance (ATCA) met regularly to advocate for improvements in Medicaid reimbursement.

The perinatal nurse consultant began collaboration with the Healthy Native Babies Project, a SIDS reduction initiative. Addressing tobacco is an important component.

In 2007, 15.5% of women reported smoking in the last three months of pregnancy, showing no appreciable change from the prior year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Convene perinatal advisory committee to address issues of infant safe sleep, including role of tobacco.				X
2. WCFH and state tobacco program will collaborate on projects related to tobacco cessation education for pregnant women and their health care providers.				X
3. Address the role of tobacco in infant sleep-related deaths via the infant safe sleep project.			X	X
4. Provide expanded and specialized Alaska Quit Line services for pregnant women.			X	
5. Participate in the Alaska Tobacco Control Alliance.				X
6. Begin work on MCH conference to include role of tobacco on the health of MCH populations.				X
7. Collaborate with Healthy Native Babies Project to reduce SIDS, addressing tobacco use.			X	
8.				
9.				
10.				

b. Current Activities

Ongoing activities from the past year continue. The tobacco treatment database project continues to work with grantees. The tobacco program hired a cessation grant manager and she and the perinatal nurse consultant have begun making plans to collaborate.

The perinatal nurse consultant has convened a steering committee and launched an infant safe sleep project, including a Healthy Native Babies consultant. The role of tobacco will be a major focus.

Free and Clear is in its third and final year of the current contract to provide Alaska Quit Line services. In addition to a more intensive follow-up for pregnant smokers, they are in the process

of developing protocols specific for pregnant callers. The perinatal nurse consultant will continue to support the Quit Line through education and referral efforts.

The tobacco program continues to participate on the Medicaid workgroup of the Alaska Tobacco Control Alliance to support the provision of cessation services. They are working to implement greater availability of treatment strategies, increased reimbursement, and the unbundling of charges to allow brief interventions to be billable.

The perinatal nurse consultant has secured a copy of an Alaska Native version of a popular tobacco cessation booklet for pregnant women and has permission to revise and reprint it. She will work with tobacco program to publish this resource.

c. Plan for the Coming Year

Activities from the current year will continue. The perinatal nurse consultant and tobacco cessation grant manager will work together on some new projects. In the early part of the year the perinatal nurse consultant will distribute the providers kits the tobacco program provides, will work together to develop and distribute a tobacco and pregnancy information sheet, and look at the possibility of reprinting the popular Alaska Native tobacco cessation booklet. Also, the perinatal nurse consultant will explore the idea of working with the tobacco program to develop a rack card to promote the Alaska Quit Line's pregnant caller services. The Tobacco Program and MCH Epi Unit will collaborate on an analysis of PRAMS tobacco data.

The infant safe sleep project will be a major focus for MCFH and the role tobacco play in sleep-related infant deaths will be addressed. Tobacco will be the topic of a perinatal advisory committee meeting this year. Also, WCFH and Alaska Native Tribal Health Consortium are partnering to organize and conduct a 2-day MCH conference in September 2010 which will address tobacco, among other topics. The perinatal nurse consultant will explore the American Academy of Family Physicians resources for tobacco cessation materials for health care providers and will explore options for partnering with other health care provider groups, e.g. family medicine physicians and public health nurses to provide cessation education.

The perinatal nurse consultant will establish a perinatal minigrants process in the coming year. Proposals related to tobacco cessation during pregnancy will likely be requested.

It is expected Free and Clear will apply for the new contract to provide Alaska Quit Line services, which will allow for renewal up to a total of 3 years. The perinatal nurse consultant will continue to support the Quit Line through education and referral efforts.

The tobacco program will work through ATCA to continue to advocate for their recommendations to increase available treatment strategies and increase Medicaid reimbursement to better support the provision of tobacco cessation services. The perinatal nurse consultant will work with the tobacco program and ATCA to promote smoking cessation ads that target pregnant women and distribute tobacco cessation materials.

These activities are infrastructure building, population-based, and enabling services.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	23.2	30	30	30	27
Annual Indicator	34.3	32.6	28.5	22.9	
Numerator	55	53	47	38	
Denominator	160424	162555	164729	166142	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	27	27	27	27	27

Notes - 2008
Source: Alaska Bureau of Vital Statistics.

The most recent data available is 2005 - 2007. This indicator is reported by 3-year moving averages.

Notes - 2007
Source: Alaska Bureau of Vital Statistics. The most recent data available is 2005 - 2007. This indicator is reported by 3-year moving averages.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

The most recent data available for FY 2009 block grant submission is 2004 - 2006. This indicator is reported by 3-year moving averages.

a. Last Year's Accomplishments
In FY08, the Division of Behavioral Health (DBH) completed its third and final year of the grant cycle the Comprehensive Prevention & Early Intervention Services program. The 25 community-based suicide prevention grantees employed prevention strategies that were designed to create a long-term impact in reducing the harmful effects of drugs and alcohol, increase resiliency and community wellness, and a reduction in suicide.

Grantee organizations ran a variety of youth programs and alternative activities such as healthy recreation programs, teen centers, sports activities, mentoring, and the reestablishment of cultural activities--subsistence, beading, carving, drumming and Alaska Native and Eskimo dance. Many programs are also learning how to best employ strategic prevention planning methods with support from the DBH project coordinators within their communities to build sustainable and cultural competent practices and evidence based prevention strategies.

Accomplishments for FY08 emphasized integrating suicide prevention programs with other behavioral health prevention strategies and activities. This is an ongoing effort that takes into account that for prevention projects and services to be effective, they also must be comprehensive and community based.

Several communities shifted to training and education including use of the Alaska Gatekeeper Suicide Prevention Training as well as other similar trainings. Schools have introduced or are

planning screening, identification and referral programs such as Signs of Suicide (SOS). Other grantees have reintroduced cultural values as key to developing holistic practices among Alaska Native youth and are using these values to implement early prevention practices among their activities.

The Suicide Prevention Council also worked closely with the DBH and grantee communities to assist in developing local suicide prevention plans and to increase community readiness. Outreach efforts were designed to promote gatekeeper and other training resources such as the evidence-based, Signs of Suicide (S0S) school-based curriculum and to promote media campaigns.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide for community-based suicide prevention grants.				X
2. Develop a statewide mechanism for delivery of the Gatekeeper Suicide Prevention training curriculum.				X
3. Promote the use of the evidence-based youth suicide prevention program, Signs of Suicide (SOS), peer helpers programs.				X
4. Participate and present at a number of statewide conferences.				X
5. Disseminate Alaska Suicide Prevention Plan and the Suicide Follow-Back Study.				X
6. Implement FY 2009 suicide prevention rural planning grants				X
7. Implement SAMHSA Alaska Youth Suicide Prevention Project (3-year grant project)				X
8.				
9.				
10.				

b. Current Activities

This Comprehensive Prevention & Early Intervention Services program was reintroduced and awarded funds for another three years. This year, 16 community-based grantees were awarded suicide prevention funding.

The Alaska Division of Behavioral Health (DBH) was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) youth suicide prevention grant. The State proposes to develop regional suicide prevention teams. Strategic plans will be developed for each region ro incorporate early prevention, intervention and post-intervention strategies to reduce suicide among youth ages 15-24 years of age.

DBH awarded four FY09 suicide prevention planning grants for rural communities with high rates of suicide. This is a one-time appropriation from the legislature and is intended to target rural communities where rates of suicide are generally higher. These four communities each received approximately $45,000 to develop strategic regional suicide prevention plans. These regional plans will be useful in tailoring comprehensive prevention strategies and drawing on local, regional, state and possibly federal resources in the future.

DBH continues to develop and expand the delivery of the Alaska Gatekeeper Suicide Prevention Training curriculum. This year, a Summer Gatekeeper Institute is being planned that will instruct new trainers, provide refresher training, and introduce a new youth module.

c. Plan for the Coming Year
FY10 will introduce the newly awarded Alaska Youth Suicide Prevention Project, and second year of the Comprehensive, Behavioral Health, Prevention and Early Intervention Services grant program. The focus for FY10 will be to provide more infrastructure to the state's suicide prevention projects, and more individualized training and technical assistance to improve the community planning process and increase successful outcomes for suicide prevention grant programs. Community grantees will increase use of community planning tools such as development of wellness teams and use of SAMHSA's Strategic Prevention Framework (SPF). The SPF incorporates the use of specific strategies that will ensure cultural responsiveness and longer term sustainability beyond grant funding.

DBH will continue to expand the Alaska Gatekeeper Training curriculum. The Summer Gatekeeper Institute will be held in July and will introduce the new youth module that is currently being developed with support from the University of Alaska Anchorage, Behavioral Health Research Services and Alaska Children's Services who also trains in the Gatekeeper model. Promotion and use of the youth module and the use of other youth suicide prevention curricula such as SOS will continue in FY10. Emphasis on capacity development to implement such programs in schools and other youth organizations will be targeted.

Also, promotion of research will continue that includes looking at acculturation and youth suicide among Alaska Native youth. Leading researchers on the subject will help to identify specific strategies associated with this population, especially for rural communities. The Alaska Native Tribal Health Consortium is interested in working closer with DBH to expand these efforts. Opportunities for rural communities to apply for and receive support for their suicide prevention efforts and research will continue to be available.

DBH will continue the strong partnership with the Statewide Suicide Prevention Council, focusing on statewide outreach, community readiness to address suicide at the local level, community planning for suicide prevention efforts, and increasing our department's focus on a broad suicide prevention initiative. The Council will also work with DBH on developing updated revisions to the Alaska Suicide Prevention Plan to be reprinted and published in early FY10.

These activities are infrastructure building, population-based, and enabling services.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	65	78	80	82	84
Annual Indicator	74.8	76.8	78.0	76.8	
Numerator	89	73	96	76	
Denominator	119	95	123	99	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86	86	90	90

Notes - 2008
Source: AK Bureau of Vital Statistics. CY 2007is most recent data available.

Notes - 2007
Source: Alaska Bureau of Vital Statistics

CY 2007is most recent data available.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

CY 2006 is most recent data available for 2009 block grant submission.

a. Last Year's Accomplishments
The perinatal nurse continued to meet with public and private health care providers and administrators at facilities across Alaska to assess perinatal health needs, collaborate on program development, and evaluate efforts. She visited the bush towns of Nome and Kotzebue. In Anchorage, she held the first perinatal advisory committee meeting, attended by 32 health care providers representing a variety of geographic areas, types of facilities, and health care professions. Members related concerns about lack of early prenatal care. They expressed interest in CenteringPregnancy and Parenting, an evidence-based program that emphasizes early prenatal care and support and reduces preterm birth.

In October 2007, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) to conduct a conference that included the STABLE course. The perinatal nurse consultant coordinated a perinatal track at the Alaska Health Summit conference December 2007. Both conferences included a session on tobacco cessation, along with other topics relevant to low birthweight. In addition to providing continuing education opportunities for health care providers, a perinatal listserv was started that has been used to share information about evidence-based programs and professional education opportunities.

WCFH has investigated some avenues to support high risk mothers since public health nursing home visits are no long available in the Anchorage area, except to clients eligible for Alaska Native health services. WCFH participated in a collaborative effort to compete for a large grant to implement an evidence-based home visiting program, but the effort was unsuccessful.

The WCFH Epi Unit continued to conduct MCH outcome data analyses and update MCH publications. Our Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health have been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

In 2007, 76.8% of low birthweight babies were born at The Children's Hospital at Providence, which has Alaska's only Level III NICU. This represents a slow trend upward from 61.5% in 1995, but still falls short of the 90% goal.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Visit health care providers and administrators across Alaska to assess issues related to transfer and transport of laboring women with complications.				X
2. Explore concern regarding timely transfer and transport of laboring women who develop complications.				X
3. Convene perinatal advisory committee on a regular basis and consider highlighting transfer/transport issue.				X
4. Lead planning for AWHONN conference and begin planning for joint MC conference in 2010, including topics related to low birthweight and appropriate transfer.				X
5. Support March of Dimes, counseling the state director and serving on the program services committee.				X
6. Support development of perinatal case manager position in Kotzebue.				X
7. Conduct MCH outcome data analyses and update MCH publications, including the MCH Fact Sheet series.				X
8. Distribute the Healthy Mother, Healthy Baby Diaries, Alaska MCH Data Books, MCH Fact Sheets, and other materials, and expand the perinatal listserv.			X	X
9.				
10.				

b. Current Activities

Ongoing activities from the past year continue. This year the perinatal nurse consultant visited the bush town of Dillingham. The perinatal advisory committee met twice. WCFH supported the February 2009 AWHONN conference, and participated in an MCH indicator project led by the city health department, which spotlighted low birthweight as one of only five indicators selected. The perinatal nurse consultant continues to support the program efforts of March of Dimes, whose national campaign is prematurity.

There is a concern among some physicians that midwives are not always transferring the care of laboring women to higher level providers soon enough. Regulations and a clear complaint process are in place and midwives have been contacted for their perspective. This will continue to be explored. The perinatal nurse consultant is supporting the development of a perinatal nurse case manager position in Kotzebue and will explore transfer and transport from that rural location.

The perinatal listserv and distribution of printed materials continue. The WCFH Epi Section continues to conduct outcome data analyses and update MCH publications. The perinatal nurse consultant will distribute the Hypertension in Pregnancy Resource Kit for Health Care Providers to birthing centers and rural clinics, in hopes of encouraging timely transfer and transport.

c. Plan for the Coming Year

Activities from the current year will continue. The perinatal advisory committee will meet in September, and WCFH will fund a number of members from the bush to travel to Anchorage for the meeting. Low birthweight will be addressed at a meeting later in the year, and committee members will be surveyed about high-risk births that occur in their communities. The perinatal nurse consultant will visit Barrow and Kodiak and address the transfer/transport issue. WCFH will continue to conduct outcome data analyses, including more thoroughly elucidating where very low birthweight babies are born when they aren't born at the tertiary care hospital. WCFH will continue to update the MCH Fact Sheets and these publications, along with previously mentioned

materials, will be distributed via personal delivery, mail, and electronically.

The perinatal nurse consultant will follow-up and further explore the issue of timely transfer/transport. She will contact MCH case managers at Alaska Native Tribal Health Consortium (ANTHC) to discuss their policies and will offer educational support to direct-entry midwives, including further distribution of the Hypertension in Pregnancy Provider Kits.

She will continue to support March of Dimes through consultation with their state director and membership on the program services committee, and support other agencies and individuals, as possible. WCFH and ANTHC are partnering to organize and conduct a 2-day MCH conference in September 2010, during which the perinatal nurse consultant will assure the transfer/transport issue is addressed. Also, she will explore options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education on the issue.

The perinatal nurse consultant will meet with managers at Providence Alaska Medical Center to discuss the possibility of establishing a rural-urban nurse exchange program to help build bridges between health care facilities, improve standards of care and birth outcomes, especially for low birthweight and preterm infants. She will also look into the possibility of supporting the Perinatal Continuing Education Program in rural areas.

These activities are infrastructure building, population-based, and enabling.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	85	85	85	85	85
Annual Indicator	81.1	80.5	81.3	80.3	
Numerator	7924	8213	8688	8584	
Denominator	9776	10197	10687	10689	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	85	85	85	85

Notes - 2008
Source: AK Bureau of Vital Statistics. CY 2007is most recent data available.

Notes - 2007
Source: AK Bureau of Vital Statistics. CY 2007is most recent data available.

Notes - 2006
Source: Alaska Bureau of Vital Statistics.

CY 2006 is the most recent data available for the 2009 block grant submission. 2007 data will be available for the 2010 BG application.

a. Last Year's Accomplishments

The perinatal nurse continued to meet with public and private health care providers and administrators at facilities across Alaska to assess perinatal health needs, collaborate on program development, and evaluate efforts. She visited the bush towns of Nome and Kotzebue. In Anchorage, she held the first perinatal advisory committee meeting, attended by 32 health care providers representing a variety of geographic areas, types of facilities, and health care professions. Members related concerns about lack of early prenatal care. They expressed interest in CenteringPregnancy and Parenting, an evidence-based program that emphasizes early prenatal care and support and reduces preterm birth.

In October 2007, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) to conduct a conference. The perinatal nurse consultant coordinated a perinatal track at the Alaska Health Summit conference December 2007. Aspects of early prenatal care were addressed in sessions on CenteringPregnancy, preconception/interconception care, and fish consumption and diabetes in pregnancy, among other topics.

A major cause of delays in initiating prenatal care had been the time it took for a pregnant woman to enroll in Medicaid. As a result of the Title V MCH director working with Medicaid, enrollment applications began being processed in as little as 2 weeks.

WCFH has investigated some avenues to support high risk mothers since public health nursing home visits are no long available in the Anchorage area, except to clients eligible for Alaska Native health services. WCFH participated in a collaborative effort to compete for a large grant to implement an evidence-based home visiting program, but the effort was unsuccessful.

A number of activities address prenatal care generally. In addition to providing continuing education opportunities for health care providers, a perinatal list serve was started that has been used to share information about evidence-based programs and professional education opportunities.

The WCFH Epi Unit continued to conduct MCH outcome data analyses and update MCH publications. Our Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health have been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

In 2007 80.3% of infants were born to women receiving prenatal care beginning in the first trimester, still falling short of the Healthy People 2010 goal of 90% or better.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Visit health care providers and administrators at facilities across Alaska and attend a Talking Circle videoconference prenatal education class for villagers.				X
2. Convene perinatal advisory committee on a regular basis and spotlight CenteringPregnancy and the launching of Alaska's infant safe sleep project.				
3. Support March of Dimes, counseling the state director and serving on the program services committee, the Municipality of				X

Anchorage, public health nursing, and others to improve perinatal outcomes.				
4. Participate in preconception planning efforts, which will likely include a component to encourage early prenatal care.			X	X
5. Lead planning for AWHONN conference and begin planning for joint MCH conference in 2010, including topics with implications for early prenatal care.				X
6. Conduct MCH outcome data analyses and update MCH publications, including the MCH Fact Sheet series.				X
7. Distribute the Healthy Mother, Healthy Baby Diaries, Alaska MCH Data Books, MCH Fact Sheets, and other materials, and expand the perinatal list serve.			X	X
8. Serve as practicum mentor to public health nurse and support development of perinatal case manager position in Kotzebue.				X
9. Explore options to support expanding prenatal care referral at facilities that provide pregnancy testing.			X	
10. Investigate models of care to support high risk mothers.				X

b. Current Activities
Ongoing activities from the past year continue. This year the perinatal nurse consultant visited the bush town of Dillingham. The perinatal advisory committee met twice this year. WCFH convened a preconception committee which meets regularly.

The perinatal nurse consultant continues to support the program efforts of March of Dimes. WCFH also participated in the Municipality of Anchorage's Healthy Anchorage Indicator project, focused on MCH.

The consultant carries on activities that educate health care providers about the importance of early prenatal care. The perinatal list serve and distribution of printed materials continue. The WCFH Epi Section continues to conduct outcome data analyses and update MCH publications. The Title V MCH Director worked with the Division of Public Assistance to improved the application processing time for prenatal Medicaid. It is hoped that this will result in an earlier acceptance into prenatal care.

The perinatal nurse consultant is the development of a perinatal nurse case manager position in Kotzebue. She is beginning to explore options to support expanding early prenatal care referral at facilities that provide pregnancy testing and include advice for early prenatal care at pregnancy test point of purchase.

WCFH continues to investigate ways to support high risk mothers. Coming up with an affordable, effective home visiting program continues to be of interest, including integration of tobacco and other substance cessation interventions.
An attachment is included in this section.

c. Plan for the Coming Year
Activities from the current year will continue. The perinatal nurse consultant will visit Barrow and other sites in Alaska during FY10. WCFH will continue to conduct outcome data analyses and update the MCH Fact Sheets. This year will see publication of a new MCH Data Book on FASD. These publications, along with previously mentioned materials, will be distributed via personal delivery, mail, and electronically. The perinatal advisory committee will meet in September, and WCFH will fund a number of members from the bush to travel to Anchorage for the meeting.

The perinatal nurse consultant will continue to support March of Dimes through consultation with their state director and membership on the program services committee, and support other

agencies and individuals, as possible. She will continue to play an active role in the preconception committee and advocate for inclusion of early prenatal care messages. Focused mass media attention on the value of preconception care and early and continuous prenatal care may be a part of this effort.

WCFH and Alaska Native Tribal Health Consortium are partnering to organize and conduct a 2-day MCH conference in September 2010. Also, the perinatal nurse consultant will explore options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education.

The perinatal nurse consultant will continue to explore options to support expanding prenatal care referral at facilities that provide pregnancy testing and include advice for early prenatal care at pregnancy test point of purchase. WCFH is actively exploring the possibility of obtaining a Medicaid Family Planning Waiver which would increase access to interconception care.

WCFH will continue to work with potential funders to identify possible pilot programs to improve birth outcomes that include early prenatal care, home visitation of high risk pregnant women, and interconception care and, specifically, care for high risk mothers. She will also track President Obama's proposal to increase funding for home visiting, with an eye to an Alaska home visiting initiative.

The section will also support legislative efforts, as requested, to increase the eligibility for Alaska's SCHIP for pregnant women, supporting early and continuous prenatal care. The MCH Title V director will continue to monitor feedback from providers regarding turnaround times for prenatal Medicaid to assure optimal starts in the first trimester.

D. State Performance Measures

State Performance Measure 1: *Percentage of mothers of newborns who say their physician or health plan would not start prenatal care as early as they wanted or they could not get an appointment as early as they wanted.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			15	15	15
Annual Indicator	14.8	12.5	16.5	14.8	
Numerator	1471	1209	1716	1517	
Denominator	9949	9697	10426	10275	
Data Source					AK PRAMS.
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15	15	15	15	13

Notes - 2008
Source: AK PRAMS. The latest available data is 2007.

Notes - 2007
Source: AK PRAMS. The latest available data is 2007.

Notes - 2006
Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

a. Last Year's Accomplishments

The perinatal nurse continued to meet with public and private health care providers and administrators at facilities across Alaska to assess perinatal health needs, collaborate on program development, and evaluate efforts. She visited the bush towns of Nome and Kotzebue. In Anchorage, she held the first perinatal advisory committee meeting, attended by 32 health care providers representing a variety of geographic areas, types of facilities, and health care professions. Members related concerns about lack of early prenatal care. They expressed interest in CenteringPregnancy and Parenting, an evidence-based program that emphasizes early prenatal care and support and reduces preterm birth.

In October 2007, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) to conduct a conference. The perinatal nurse consultant coordinated a perinatal track at the Alaska Health Summit conference December 2007. Aspects of early prenatal care were addressed in sessions on CenteringPregnancy, preconception/interconception care, and fish consumption and diabetes in pregnancy, among other topics.

A major cause of delays in initiating prenatal care had been the time it took for a pregnant woman to enroll in Medicaid. As a result of the Title V MCH director working with Medicaid, enrollment applications began being processed in as little as 2 weeks.

WCFH has investigated some avenues to support high risk mothers since public health nursing home visits are no long available in the Anchorage area, except to clients eligible for Alaska Native health services. WCFH participated in a collaborative effort to compete for a large grant to implement an evidence-based home visiting program, but the effort was unsuccessful.

A number of activities address prenatal care generally. In addition to providing continuing education opportunities for health care providers, a perinatal list serve was started that has been used to share information about evidence-based programs and professional education opportunities.

The WCFH Epi Unit continued to conduct MCH outcome data analyses and update MCH publications. The Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health have been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Visit health care providers and administrators at facilities across Alaska and attend a Talking Circle videoconference prenatal education class for villagers.				X
2. Convene perinatal advisory committee on a regular basis and spotlight CenteringPregnancy and the launching of Alaska's infant safe sleep project.				X
3. Support March of Dimes, counseling the state director and serving on the program services committee, the Municipality of Anchorage, public health nursing, and others to improve				X

perinatal outcomes.				
4. Participate in preconception planning efforts, which will likely include a component to encourage early prenatal care.			X	X
5. Lead planning for AWHONN conference and begin planning for joint MCH conference in 2010, including topics with implications for early prenatal care.				X
6. Conduct MCH outcome data analyses and update MCH publications, including the MCH Fact Sheet series.				X
7. Distribute the Healthy Mother, Healthy Baby Diaries, Alaska MCH Data Books, MCH Fact Sheets, and other materials, and expand the perinatal list serve.			X	X
8. Serve as practicum mentor to public health nurse and support development of perinatal case manager position in Kotzebue.				X
9. Explore options to support expanding prenatal care referral at facilities that provide pregnancy testing.			X	X
10. Investigate models of care to support high risk mothers.				X

b. Current Activities

Ongoing activities from the past year continue. This year the perinatal nurse consultant visited the bush town of Dillingham. The perinatal advisory committee met twice this year. WCFH convened a preconception committee which meets regularly.

The perinatal nurse consultant continues to support the program efforts of March of Dimes. WCFH also participated in the Municipality of Anchorage's Healthy Anchorage Indicator project, focused on MCH.

The consultant carries on activities that educate health care providers about the importance of early prenatal care. The perinatal list serve and distribution of printed materials continue. The WCFH Epi Section continues to conduct outcome data analyses and update MCH publications. The unit published a postpartum depression Epi Bulletin.

The perinatal nurse consultant is the practicum mentor for a public health nurse and is supporting the development of a perinatal nurse case manager position in Kotzebue. She is beginning to explore options to support expanding early prenatal care referral at facilities that provide pregnancy testing and include advice for early prenatal care at pregnancy test point of purchase.

WCFH continues to investigate ways to support high risk mothers in Alaska. Coming up with an affordable, effective home visiting program continues to be of interest, including integration of tobacco and other substance cessation interventions.

c. Plan for the Coming Year

Activities from the current year will continue. The perinatal nurse consultant will visit Barrow and other sites in Alaska during FY10. WCFH will continue to conduct outcome data analyses and update the MCH Fact Sheets. This year will see publication of a new MCH Data Book on FASD. These publications, along with previously mentioned materials, will be distributed via personal delivery, mail, and electronically. The perinatal advisory committee will meet in September, and WCFH will fund a number of members from the bush to travel to Anchorage for the meeting.

The perinatal nurse consultant will continue to support March of Dimes through consultation with their state director and membership on the program services committee, and support other agencies and individuals, as possible. She will continue to play an active role in the preconception committee and advocate for inclusion of early prenatal care messages. Focused mass media attention on the value of preconception care and early and continuous prenatal care

may be a part of this effort.

WCFH and Alaska Native Tribal Health Consortium are partnering to organize and conduct a 2-day MCH conference in September 2010. Also, the perinatal nurse consultant will explore options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education.

The perinatal nurse consultant will continue to explore options to support expanding prenatal care referral at facilities that provide pregnancy testing and include advice for early prenatal care at pregnancy test point of purchase. WCFH is actively exploring the possibility of obtaining a Medicaid Family Planning Waiver which would increase access to interconception care.

WCFH will continue to work with potential funders to identify possible pilot programs to improve birth outcomes that include early prenatal care, home visitation of high risk pregnant women, and interconception care and, specifically, care for high risk mothers. She will also track President Obama's proposal to increase funding for home visiting, with an eye to an Alaska home visiting initiative.

The section will also support legislative efforts, as requested, to increase the eligibility for Alaska's SCHIP for pregnant women, supporting early and continuous prenatal care.

State Performance Measure 2: *Percent of women who smoked during the last 3 months of pregnancy among women who smoked 3 months prior to pregnancy and were talked to about the effects of smoking by a prenatal health care provider.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			99	99	60
Annual Indicator	58.5	53.8	51.5	60.1	
Numerator	1561	1283	1314	1431	
Denominator	2667	2383	2550	2382	
Data Source					AK PRAMS.
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	60	55

Notes - 2008
Source: AK PRAMS. The latest available data is 2007.

Notes - 2007
Source: AK PRAMS. The latest available data is 2007.

Notes - 2006
Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

MCH-Epi staff contributed to the following journal article:
Kim SY, England L, Dietz P, Morrow B, Perham-Hester KA. (2008)Prenatal cigarette smoking and smokeless tobacco use among Alaska Native and white women in Alaska, 1996 - 2003. Matern Child Health J. Springer Science+Business Meedia.

a. Last Year's Accomplishments

The perinatal nurse continued to meet with public and private health care providers and administrators at facilities across Alaska to assess perinatal health needs (including tobacco-related needs), collaborate on program development, and evaluate efforts. She visited the bush towns of Nome and Kotzebue, where tobacco use during the last 3 months of pregnancy is especially high. In Anchorage, she held the first perinatal advisory committee meeting, attended by 32 health care providers representing a variety of geographic areas, types of facilities, and health care professions. Members expressed interest in tobacco cessation efforts. WCFH participated in a project to support the city health department in a MCH indicator project.

The WCFH Epidemiology Unit continued to conduct MCH outcome data analyses and update MCH publications. WCFH Epi Unit and state tobacco program collaborated on an in-depth analysis of BRFSS and PRAMS data related to tobacco cessation.

Our Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health have been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes comprehensive health information on pregnancy and infant care, tobacco cessation booklets, and other materials furnished through Title V funding were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

In October 2007, Title V again collaborated with the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) to conduct a conference. The perinatal nurse consultant coordinated a perinatal track at the Alaska Health Summit conference December 2007. Both conferences included a session on tobacco cessation. Also, a perinatal list serve was started that has been used to share information about evidence-based programs and professional education opportunities.

Progress continued on the tobacco treatment database project, which expanded to a total of 9 grantees. In November Free and Clear took over The Alaska Quit Line contract from Providence. They have implemented a more intensive, new pregnant caller program. The perinatal nurse consultant promoted the Alaska.

A method of billing for smoking cessation counseling and medications was established in SFY 06 for Medicaid patients who are pregnant and those under 21 years of age. Medicaid providers who are physicians, nurse practitioners, and community health aides may bill for these services. The Medicaid workgroup of Alaska Tobacco Control Alliance (ATCA) met regularly to advocate for improvements in Medicaid reimbursement.

The perinatal nurse consultant began collaboration with the Healthy Native Babies Project, a SIDS reduction initiative. Addressing tobacco is an important component.

That, in 2007, 60.1% of women who smoked 3 months prior to pregnancy and were talked to about tobacco effects by a prenatal provider continued to smoke during pregnancy speaks to the persistent problem of tobacco use.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Convene perinatal advisory committee to address issues of infant safe sleep, including role of tobacco.				X
2. WCFH and state tobacco program will collaborate on projects related to tobacco cessation education for pregnant women and their health care providers.				X

3. Address the role of tobacco in infant sleep-related deaths via the infant safe sleep project.			X	X
4. Provide expanded and specialized Alaska Quit Line services for pregnant women.			X	X
5. Participate in the Alaska Tobacco Control Alliance.				X
6. Begin work on MCH conference to include role of tobacco on the health of MCH populations				X
7. Collaborate with Healthy Native Babies Project to reduce SIDS, addressing tobacco use.			X	X
8.				
9.				
10.				

b. Current Activities
Ongoing activities from the past year continue. The tobacco treatment database project continues to work with grantees. The tobacco program hired a cessation grant manager and she and the perinatal nurse consultant have begun making plans to collaborate.

The perinatal nurse consultant has convened a steering committee and launched an infant safe sleep project, including a Healthy Native Babies consultant. The role of tobacco will be a major focus.

Free and Clear is in its third and final year of the current contract to provide Alaska Quit Line services. In addition to a more intensive follow-up for pregnant smokers, they are in the process of developing protocols specific for pregnant callers. The perinatal nurse consultant will continue to support the Quit Line through education and referral efforts.

The tobacco program continues to participate on the Medicaid workgroup of the Alaska Tobacco Control Alliance to support the provision of cessation services. They are working to implement greater availability of treatment strategies, increased reimbursement, and the unbundling of charges to allow brief interventions to be billable.

The perinatal nurse consultant has secured a copy of an Alaska Native version of a popular tobacco cessation booklet for pregnant women and has permission to revise and reprint it. She will work with tobacco program to publish this resource.

c. Plan for the Coming Year
Activities from the current year will continue. The perinatal nurse consultant and tobacco cessation grant manager will work together on some new projects. In the early part of the year the perinatal nurse consultant will distribute the providers kits the tobacco program provides, will work together to develop and distribute a tobacco and pregnancy information sheet, and look at the possibility of reprinting the popular Alaska Native tobacco cessation booklet. Also, the perinatal nurse consultant will explore the idea of working with the tobacco program to develop a rack card to promote the Alaska Quit Line's pregnant caller services. The Tobacco Program and MCH Epi Unit will collaborate on an analysis of PRAMS tobacco data.

The infant safe sleep project will be a major focus for MCFH and the role tobacco play in sleep-related infant deaths will be addressed. Tobacco will be the topic of a perinatal advisory committee meeting this year. Also, WCFH and Alaska Native Tribal Health Consortium are partnering to organize and conduct a 2-day MCH conference in September 2010 which will address tobacco, among other topics. The perinatal nurse consultant will explore the American Academy of Family Physicians resources for tobacco cessation materials for health care providers and will explore options for partnering with other health care provider groups, e.g. family

medicine physicians and public health nurses to provide cessation education.

The perinatal nurse consultant will establish a perinatal minigrants process in the coming year. Proposals related to tobacco cessation during pregnancy will likely be requested

It is expected Free and Clear will apply for the new contract to provide Alaska Quit Line services, which will allow for renewal up to a total of 3 years. The perinatal nurse consultant will continue to support the Quit Line through education and referral efforts.

The tobacco program will work through ATCA to continue to advocate for their recommendations to increase available treatment strategies and increase Medicaid reimbursement to better support the provision of tobacco cessation services. The perinatal nurse consultant will work with the tobacco program and ATCA to promote smoking cessation ads that target pregnant women and distribute tobacco cessation materials.

These activities are infrastructure building, population-based, and enabling services.

State Performance Measure 3: *Percentage of children ages 10-11 who are at-risk for being overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			0	0	35
Annual Indicator	40.1	40.1	40.1	40.1	39.7
Numerator	6783	6783	6783	6783	
Denominator	16901	16901	16901	16901	
Data Source					National Survey of Children's Health, 2007
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	35	35	35	35

Notes - 2008
Source: National Survey of Children's Health, 2007. Starting with the survey year 2007, this indicator is reported for 10 - 13 year olds and represents overweight and obese, 85th percentile and above.

Notes - 2007
Source: National Survey of Children's Health, Alaska, 2003, Physical and Dental Health. No new information since 2003.

Notes - 2006
Source: National Survey of Children's Health, Alaska, 2003, Physical and Dental Health. Retrieved April 23, 2006 from http://nschdata.org/anonymous/dataquery/DataQuery.aspx?control=0.

the indicator is 40.1%. Data was based on a sample and sample sizes were too small to meet standards for reliability or precision. The relative standard error is greater than 30%.

Denominator excludes unknown information. 2003 is the baseline data and is the latest available figure.

a. Last Year's Accomplishments
The Alaska Obesity Prevention and Control Program (OPCP) established the Alaska Obesity Prevention list serve as a two-way communication tool to increase awareness and provide technical assistance to our partners about obesity prevention and control 175 individuals are subscribed. Staff provided technical assistance to establish an intradepartmental website to provide one-way communication encouraging healthy behaviors. www.livewell.alaska.gov

OPCP staff trained over 75 child care providers re: physical activity and nutrition in five communities: Anchorage, Juneau, Fairbanks, Mat-Su, and Homer. The 2008 School Wellness Institute was attended by 70 school staff from 20 different school districts.

The OPCP financially supported professional education opportunities at the Alaska Public Health Association annual conference and the Get Outdoors! Summit. The program also promoted Bike to Work Day in Anchorage drawing over 1,300 riders.

Efforts to secure funding from the CDC Division of Nutrition, Physical Activity, and Obesity Cooperative Agreement for the OPCP did not materialize.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing technical assistance in the development of a website to provide one-way communication encouraging healthy behaviors.				X
2. Presented to health professionals to increase knowledge about evidence based obesity prevention strategies.				X
3. Offering professional development opportunities (Child care providers, school wellness policies, breastfeeding support in the workplace).				X
4. Collaborating with partners (Anchorage Mayor's Obesity prevention staff, Bike to Work Day, Get Outdoors, and Healthy Lifestyles)				X
5. Presenting poster at Weight of the Nation conference regarding our findings: Prevalence of Overweight and Obesity among Anchorage School District Students, 1998-2008.				X
6. Securing sustained funding for the OPCP.				X
7. Publishing technical reports on obesity surveillance in Alaska (Childhood Obesity in Alaska, Prevalence of Overweight and Obesity among Anchorage School District Students, 1998-2008 ,and 2009 Burden of Obesity in Alaska report).				X
8. Collecting additional surveillance information.				X
9.				
10.				

b. Current Activities
OPCP staff presented many educational activities to a variety of audiences. Staff prepared Prevalence of Overweight and Obesity among Anchorage School District Students, 1998-2008 and presented findings locally and nationally.
http://www.hss.state.ak.us/dph/chronic/pubs/assets/ChroniclesV2-1.pdf OPCP prepared and distributed the document, Childhood Obesity in Alaska.

http://www.hss.state.ak.us/dph/chronic/obesity/pubs/Childhood_Obesity.pdf Staff is completing the Burden of Overweight and Obesity in Alaska document.

OPCP financially supported professional education opportunities at the HRSA Business Case for Breastfeeding in the Workplace. They provided technical assistance in the development of an intradepartmental website to encourage healthy behaviors. www.livewell.alaska.gov .

Staff worked with the Anchorage Mayor's Obesity prevention staff to develop a grant application to improve the ability of local and state coalitions to implement Municipal and State plans. OCPC staff conducted an inventory of obesity prevention efforts across the state.

The program promoted the 2009 Bike to Work and School Day in Anchorage. Staff supports the Get Outdoors! Alaska coalition to increase the amount of time children, youth and families spend outdoors.
OCPC staff has been active in the development with the Title V WCFH-led effort for a preconception health plan and in the Coordinated School Health effort underway in collaboration with the Department of Education and Early Development.

c. Plan for the Coming Year
The OCPC staff plan to complete the following activities in FY10. Title V WCFH staff participate actively in these activities through the adolescent health program and the school health program.

OCPC will facilitate meetings of Take Heart Alaska Healthy Lifestyles coalition for shared planning, implementation, and sustainability of program efforts and facilitate the Eat Smart Alaska coalition. They will coordinate a face-to-face meeting of statewide Healthy Lifestyles coalition. Healthy Lifestyles will review state plan and develop strategic two-year implementation plan based on goals and objectives of state plan.

OCPC will expand surveillance plan to address current needs in relationship to the evaluation measures of the state plan and identify new surveillance sources or opportunities to add nutrition-, physical activity- and obesity-related questions.

They will present at a minimum of 6 conferences or meetings and provide professional education opportunities with national speakers for partners at statewide conferences or meetings to increase knowledge about obesity issues. They have submitted presentation proposals to the American Public Health Association annual conference regarding our findings: Prevalence of Overweight and Obesity among Anchorage School District Students, 1998-2008.

OCPC will contract with evaluation specialist to collect and assess the remaining school district wellness policies and produce and disseminate a report about the policy. They will plan and coordinate the annual School Health and Wellness Institute that supports the implementation of wellness policies based on evidence- based programs and practices, as well as providing technical assistance to school districts on policies. Also, they will expand school BMI data collection and analysis project to one additional school in Alaska.

OCPC will continue to partner with Bicycle Commuters of Anchorage and others to promote Bike to Work Day and partner with the Safe Routes to School Program to promote Walk to School Day. They also will continue to partner with Get Outdoors! Alaska and others to promote increased outdoor physical activity and play.

They will continue to partner with the preconception health committee to promote healthy weight for preconception girls and women. They will also partner with the Alaska Breastfeeding Coalition and the Municipality of Anchorage to develop a plan to improve breastfeeding conditions in the workplace statewide.

OCPC will also: participate on the Anchorage Mayor's Obesity Task Force, Healthy Anchorage Steering Committee and RWJF Healthy Communities grant activities; participate in the DHSS Live Well website planning process and; partner with the State Nutrition Action Plan's coalition to promote the More Matters campaign. They continue to develop a comprehensive child obesity initiative and secure State funding and distribute the Burden of Obesity in Alaska.

All activities are population-based and infrastructure building.

State Performance Measure 4: *Rate (per 1,000) of substantiated reports of harm children ages 0 through 18.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	17	17	17	17	12
Annual Indicator	20.5		15.2	14.8	18.1
Numerator	19809		3113	3209	3757
Denominator	965594		205460	217105	208090
Data Source					AK Office of Children's Services
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	12	12	12	12

Notes - 2007
Data source: AK Office of Children's Services

The numerator for 2006 is changed from 4543 to 3113. This corrects an error last year in the interpretation of the definition of the numerator. To reconfirm, the numerator is the 'count of children with at least one allegation substantiated'.

Notes - 2006
Source: Alaska Office of Children's Services

FY 2006 is reported as a single year whereas prior years were reported as five year moving averages. The numerator excludes 72 individuals whose birthdates were missing, some of whom might have been in this age group.

a. Last Year's Accomplishments
The Strengthening Families (SF) Leadership Team continued to work toward statewide expansion of the model and embedding this framework in state policies and systems. The criteria for programs interested in becoming a SF early care and learning program was finalized and the SF training orientation was standardized. Data collection continued regarding the practice changes made in SF programs.

The Alaska Association for the Education of Young Children partnered with the SF Leadership Team to sponsor a cross-sector train-the-trainer weeklong event on SF and the "Stronger Together" curriculum. Support continued to SF programs through the "Learning Network" monthly conference calls. A statewide meeting with SF programs was held to share information and discuss program progress. The SF Leadership Team continued working with the early childhood professional development registry to incorporate SF and family support training into their system designed to track training and to certify levels of accomplishment. Presentations on the SF

approach were made at statewide conferences.

Efforts have expanded in the child protection system. The Alaska SF coordinator and the Office of Children's Services (OCS) director attended a meeting with a cohort of states leading the effort to incorporate the SF framework into their child protection systems. Through a partnership of the OCS and the Child Care Program Office, the provision of childcare assistance to foster parents was significantly increased.

The state leadership team continued its involvement with the National Strengthening Families Network and the National Alliance of Children's Trust and Prevention Funds Early Childhood Initiative.

The program partnered with United Way of Anchorage to submit a proposal for "Strengthening Families United" funding from the national United Way of America organization. That proposal was funded and work began to expanding the SF program to additional early care and learning programs in the Anchorage area.

Alaska SCAN is a new WCFH program that gathers data on child maltreatment from a variety of sources, such as vital statistics, police reports, medical examiner reports, hospital records, child protective services, etc. Individually, these sources provide fragmented data about maltreatment in a narrow context but together, these sources offer a more complete picture of the circumstances surrounding maltreatment. A few of the benefits from this system will include being able to identify points for interventions, trends or change over time, effectiveness of interventions, risk factors for maltreatment, and accurate numbers as to the actual burden of child maltreatment in Alaska. Program details are described in the Epi Bulletin (http://www.epi.alaska.gov/bulletins/docs/b2008_06.pdf).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work toward statewide expansion of SF model through Anchorage UW partnership, curriculum materials for Juneau and Fairbanks, and conference presentations				X
2. Engage family support agencies in conversations about SF tools and framework.				X
3. Work to embed this framework in state policies and systems through Family & Youth Training Academy and grant language				X
4. Continue to support SF programs through the Learning Network.				X
5. Partner with Alaska Children’s Trust on community café projects.			X	
6. Develop new SF materials for distribution.			X	X
7. Finalize a new strategic plan				X
8. Continue to gather data on child maltreatment from a variety of sources through Alaska SCAN to help track child maltreatment and plan interventions.				X
9.				
10.				

b. Current Activities

The program is partnering with United Way of Anchorage, the Alaska Children's Trust and the Alaska Child Care Resource and Referral Network to expand the number of SF programs in the Anchorage area. Staff for new programs are being recruited, trained and supported with technical

assistance. Program changes and family outcomes are being evaluated. OSC is engaging in conversations with family support agencies about how SF tools and information might be adapted to their work.

OCS funding is being provided to the child care resource and referral agencies in Juneau and Fairbanks to purchase curriculum materials to expand training in the state. They also are developing new SF materials and seeking out new partners and resources.

OCS is continuing to focus on embedding this framework in state policies and systems, including in training for all new social workers and embedding protective factors language in grant requirements.

OCS is collaborating with the Alaska Children's Trust on the development of a statewide prevention plan and the PREVENT Maltreatment Project. Both projects incorporate the protective factors and the use of community cafés to engage parents and community members in discussions.

The Strengthening Families Leadership Team is finalizing a strategic plan that will lay the foundation for the next three years.

Alaska SCAN continues to gather data on child maltreatment from a variety of sources to help tract and intervene related to child maltreatment.

c. Plan for the Coming Year

OCS will be implementing the goals and strategies in our finalized strategic plan. This will include developing leadership skills in parents, continuing our work toward statewide expansion of the model in early care and learning programs and embedding this framework in state policies, systems and professional development efforts.

We will support new efforts in the Fairbanks and Juneau areas, as well as continue working with our partners on the United Way project in Anchorage. We will be working to develop tools for family support agencies to assist them in being more intentional about supporting the protective factors for families.

We will be utilizing the information gathered from the community cafés to inform our practice. The insights gained will be incorporated into our training and our materials.

Next year we will be expanding our outreach to programs and enhancing our statewide website. We will continue to expand our partnerships and continue to search for additional funding.

Alaska SCAN will continue to provide the necessary information to guide and support the efforts of all the different agencies in Alaska concerned with reducing child maltreatment. Funding opportunities are being sought.

These activities are infrastructure building and enabling services.

State Performance Measure 5: *Percentage of women who recently had a live-born infant who reported their prenatal health care provider advised them not to drink alcohol during their pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective			99	99	99
Annual Indicator	80.3	79.5	82.6	80.0	
Numerator	7718	7629	8481	8326	
Denominator	9615	9598	10268	10402	
Data Source					AK PRAMS
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99	99	99	99	99

Notes - 2008
Source: AK PRAMS. The latest available data is for 2007.

Notes - 2007
Source: AK PRAMS. The latest available data is for 2007.

Notes - 2006
Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

a. Last Year's Accomplishments
The Epidemiology Unit of WCFH began work on a special edition of the MCH Data Book that will feature the first comprehensive data published on FASD since the inception of the surveillance program. The data featured in this edition will represent data collected between 1996 and 2002. Staff worked on completing abstractions and re-abstractions on all children reported to the Alaska Birth Defects Registry as having been affected by maternal alcohol exposure with birth years 1996-2002.

The perinatal nurse continued to meet with public and private health care providers and administrators at facilities across Alaska to assess perinatal health needs, collaborate on program development, and evaluate efforts. She visited the bush towns of Nome and Kotzebue. In Anchorage, she held the first perinatal advisory committee meeting, attended by 32 health care providers representing a variety of geographic areas, types of facilities, and health care professions. Alcohol use during pregnancy, among other topics, is discussed.

A number of her activities address prenatal care generally. In addition to providing continuing education opportunities for health care providers, a perinatal list serve was started that has been used to share information about evidence-based programs and professional education opportunities, including those related to FASD prevention.

The WCFH Epi Unit continued to conduct MCH outcome data analyses and update MCH publications. Our Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health have been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes FASD among other health education topics on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

In 2007 80% of women who recently delivered a baby reported having been advised to avoid alcohol by their health care provider. This remains somewhat steady since 2004.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue funding the ABDR/FAS data surveillance program with the MCH Block Grant.				X
2. Continue FAS data abstraction and data cleaning in preparation for analysis and MCH Data Book publication.				X
3. Develop and distribute interim publications based on FAS data analysis.				X
4. Continue health care provider education regarding alcohol abstinence during pregnancy, including the sharing of prevalence rates of FAS				X
5. Update and continue distribution across Alaska of the WCFH MCH Fact Sheet on FAS.				X
6. Continue regular distribution of Alaska Birth Defects Monitor, a newsletter that includes FASD.				X
7. Address FASD prevention in preconception committee efforts.				X
8.				
9.				
10.				

b. Current Activities

Under the Alaska Birth Defects Registry (ABDR), FAS surveillance activities continue using the CDC FASSNet model. MCH Epi continues medical records abstractions and data cleaning in preparation for the special edition of the MCH Data Book that will feature 1996-2002 FASD data, the first comprehensive data published since the inception of the surveillance program. Records abstraction for the 2003 birth cohort has begun. The ABDR coordinator presented preliminary FASD data for 1996-2002 birth years at statewide meetings. An MCH epidemiologist authored and published an Epi Bulletin with birth defects prevalence data, including FASD, for birth years 1996-2002. ABDR staff met with the Director and staff of the new Arctic FASD Regional Training Center (http://www.uaa.alaska.edu/arcticfasdrtc/) to discuss potential for collaboration. We published the Alaska Birth Defects Monitor, a newsletter about birth defects in Alaska, to include FASD.

The perinatal nurse consultant's activities from the past year continue. This year she visited the bush town of Dillingham. The perinatal advisory committee met twice. WCFH convened a preconception committee which will address FASD. The perinatal nurse consultant is exploring options to support expanding early prenatal care referral at facilities that provide pregnancy testing and at pregnancy test point of purchase, including advice to avoid alcohol, tobacco and other substances.

c. Plan for the Coming Year

The special edition of the MCH Data Book focusing on FASD will be published via the web and hard copy and distributed to as many providers of obstetrical and newborn care as possible. Medical records abstractions for children reported to the ABDR as having been affected by maternal alcohol exposure will continue.

WCFH will work collaboratively with the newly established Arctic FASD Regional Training Center in Anchorage to reach health care providers statewide with information about FASD prevalence and high risk populations so that they may better target prevention efforts and be informed about trends over time. MCH Epi will also continue to publish the Alaska Birth Defects Monitor newsletter.

The perinatal nurse consultant will continue to visit sites across Alaska and distribute WCFH-

published data and other selected materials, including those on FASD prevention. A revision of the Healthy Mother, Healthy Baby Diary, that includes FASD prevention information, will get into full swing in the coming year, in anticipation of a reprinting.

The perinatal advisory committee will meet in person in Fall 2009 and twice by teleconference later in the year. Tentatively, FASD will be the focus of the Spring 2010 meeting. She will continue to pursue options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education on FASD.

WCFH will work with Alaska Division of Behavioral Health to distribute FASD materials and recognize Birth Defects Prevention Month in January. The perinatal nurse consultant will work with the Anchorage FASD coalition to promote and recognize FAS Awareness Day in September.

WCFH will continue to work toward supporting high risk women in the prevention of FASD. Coming up with an affordable, effective home visiting program continues to be of interest, including integration of alcohol, tobacco and other substance cessation interventions.

These are infrastructure building and population-based activities.

State Performance Measure 6: *Prevalence (per 100) of unintended pregnancies that resulted in a live birth among women who reported having a controlling partner during the 12 months prior to getting pregnant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			35	35	35
Annual Indicator	52.0	51.1	69.4	50.7	
Numerator	239	191	245	219	
Denominator	460	374	353	432	
Data Source					AK PRAMS
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	35	35	35	35

Notes - 2008
Source: AK PRAMS. The latest available data is for 2007.

Notes - 2007
Source: AK PRAMS. The latest available data is for 2007.

The data for this reporting year marked decreased from the year prior and is closer to the rates reported in 2004 and 2005. Staff will monitor future data to ascertain if this is an ongoing trend or not.

Notes - 2006
Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

a. Last Year's Accomplishments
The Alaska Family Violence Prevention Project (AFVPP) participated in the steering committee for the DELTA (Domestic Violence Prevention Enhancement and Leadership Through Alliances)

primary prevention initiative for intimate partner violence in Alaska.

AFVPP worked with a community coalition for Prince of Wales Island on their prevention plan for intimate partner violence and conducted a series of community-based trainings through April, 2008.

AFVPP published a number of articles last year. They published an article on primary prevention of intimate partner violence for the Violence Against Women Network (VAWNET) and an article on intimate partner violence and home visitation services in the Journal of Emotional Abuse. They published an article on the impact of intimate partner violence on families in the Anchorage Daily News and was featured on an interactive radio show to talk about intimate partner violence as a family health issue.

AFVPP also provided several trainings. They provided training on dating violence for school districts and tribal governments in Fairbanks and Fort Yukon. They conducted training on the health effects of intimate partner violence, including unintended pregnancy, for the Alaska Public Health Association's annual conference and the Native Health Summit. They conducted training on the dynamics and impact of intimate partner violence on families and health for the Office of Children's Services in Kenai. AFVPP conducted training on adolescent brain development, dating violence, and sexual risk behaviors for the annual child maltreatment conference.

AFVPP provided technical assistance to Section of Public Health Nursing on expanding their protocol to address lifetime exposure to violence, enhance documentation practices, and provided training on evidence-based strategies to address intimate partner violence with pregnant women at their statewide conference.

AFVPP, in partnership with the Alaska Council on Domestic Violence and Sexual Assault, conducted a statewide survey of service agencies and community organizations on primary prevention strategies for sexual assault and coerced sex.

AFVPP compiled data on sexual assault and coerced sex including dating violence and intimate partner violence and created a PowerPoint presentation with speakers' notes that is being disseminated statewide.

AFVPP developed a training toolkit on intimate partner violence and reproductive health with emphasis on controlling partners, birth control sabotage, and unintended pregnancy. The AFVPP Clearinghouse distributed screening tools, information on evidence-based strategies, posters, safety information cards, and brochures on intimate partner violence around the time of pregnancy.

AFVPP was featured in a federally-funded DVD on intimate partner violence that helps parents to recognize that threatening behaviors and emotional abuse are forms of violence that is harmful to adults and children. AFVPP has distributed this DVD throughout Alaska.

In 2007, 50.7 % of women who had a live birth and a controlling partners reported that they had an unintended pregnancy. This number is down from 69.6 % in 2006, but on par with 2004 and 2005 levels.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to operate the clearinghouse to disseminate resources on intimate partner violence throughout Alaska.			X	X
2. Develop a curriculum for service providers on adolescent brain				X

development, sexual risk behaviors, and dating violence.				
3. Develop a curriculum for teens on adolescent brain development, sexual risk behaviors and dating violence.			X	
4. Help to develop a 5-year prevention plan on preventing sexual assault and coerced sex in Alaska.			X	
5. Publish an article on adolescent brain development and the interface with dating violence and risk behaviors.			X	X
6. Help to design a statewide survey on intimate partner violence.				X
7. Provide training for service providers, educators, foster parents, and teens in Anchorage, Dillingham, Sitka, Kenai, Homer, Juneau, and statewide conferences.			X	X
8. Work on a proposal to evaluate a prevention curriculum on healthy relationships, sexuality, and substance abuse in schools.				X
9. Assist with the adaptation of the 4th R curriculum for Alaska high school students.			X	X
10. Participate on the steering committee for national conference and help to design a pre-conference on violence and reproductive health.				X

b. Current Activities

AFVPP serves on a statewide steering committee for rape prevention education and is helping to develop a five-year prevention plan for sexual assault and coerced sex. AFVPP and the State adolescent health program (AHP) serve on the steering committees for DELTA. AFVPP also serves on the 2009 National Conference on Domestic Violence and Health Care.

AFVPP is assisting with pilot testing and adaptation of the 4th R prevention curriculum with high school students. AFVPP and the State AHP are collaborating on a grant proposal to fund evaluation of the 4th R prevention curriculum in several high schools.

AFVPP is developing a curriculum for service providers on adolescent brain development, dating violence, and sexual risk behaviors that addresses early initiation of sex, birth control sabotage, and unintended pregnancies.

AFVPP conducts training on intimate partner violence in Anchorage, Sitka, Juneau, Kenai, Homer, and web-based training for the public health nurses and provides technical assistance on screening to public health agencies and service providers. AFVPP provides education on the adolescent brain development, dating violence and risk behaviors in Sitka, Homer, Girdwood, and Dillingham.

Other activities include publishing an article on adolescent brain development and risk behaviors and assisting in the design of a statewide, population-based survey on intimate partner violence. Also, AFVPP Clearinghouse continues to develop and distribute tools and resources.

c. Plan for the Coming Year

AFVPP will publish a chapter on the primary prevention of intimate partner violence that addresses reproductive health strategies in a textbook for health care providers. Also, they will publish an educational article on adolescent brain development and the interface with sexual risk behaviors and unhealthy relationships in a major newspaper in Alaska.

AFVPP will do a presentation that integrates the concept of youth leadership in promoting healthy brain development and preventing dating violence and risk behaviors such as early initiation of sex and unprotected sex at a youth leadership conference in Girdwood. They will present at a

one-day pre-conference on reproductive health and intimate partner violence at the National Conference on Domestic Violence and Health Care in New Orleans and publish the results. They also will do presentations on intimate partner violence in southeast Alaska and trainings in at least three other communities/regions.

The AHP will provide trainings to health care providers, school personnel and parents on promoting teen healthy relationships and will host a speaker for a call-in radio show on teen pregnancy prevention, including violence and sexual assault as contributing factors.

The AHP will assist in the planning of a teen leadership summit where issues of domestic violence will be addressed and will work with youth in Alaska to design and distribute a multimedia campaign on healthy relationships.

AFVPP and AHP will continue to participate on the steering committees for DELTA and rape prevention education.

AFVPP will conduct a statewide survey with health care providers on dating violence and related risk behaviors and outcomes including unintended pregnancy.

The AFVPP Clearinghouse will continue to develop and distribute tools and materials and provide training to communities, youth, domestic violence advocacy agencies, public health agencies, non-profits, health care providers, teachers, school personnel, and other organizations and service providers.

These activities are infrastructure building and population-based services.

State Performance Measure 7: *Percentage of women who recently had a live-born infant who reported that they always or often felt down, depressed, or hopeless since their new baby was born.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			1.5	9	8
Annual Indicator	10.8	9.3	8.5	8.3	
Numerator	1065	914	888	873	
Denominator	9851	9807	10485	10553	
Data Source					AK PRAMS
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	8	8	8	8

Notes - 2008
Source: AK PRAMS. The latest available data is for 2007.

Notes - 2007
Source: AK PRAMS. The latest available data is for 2007.

Notes - 2006
Source: Alaska PRAMS

The latest available data is for 2006. Data for 2007 will be available for the FY 2010 block grant application.

a. Last Year's Accomplishments
The perinatal mood disorder navigator completed development of the educational packet that included the Edinburgh Postnatal Depression Scale. Packets were distributed to 1000 health care providers across the state. Title V dollars were used to fund printing and mail the packets.

Perinatal mood disorder navigator trained health care providers on the importance of screening every mother for depression at her prenatal and postpartum visits. Trainees included Providence nursing staff and case managers, social workers, and military health care personnel. She started a support group, fielded referrals from hospital staff, and provided direct counseling services.

The WCFH continued to support the project. At the Alaska Health Summit in December 2007 Title V supported a perinatal and women's health track that included a session on postpartum depression. The Alaska MCH Data Book-PRAMS Edition and the MCH Fact Sheet, entitled Maternal Mental Health, were widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that also includes information on postpartum depression, along with other materials furnished through Title V funding, were distributed to a large number of facilities across Alaska.

Postpartum depression also was a focus for the Early Childhood Comprehensive Systems Grant (ECCS) as part of the early behavioral/mental health identification and intervention efforts.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct continuing education and training sessions for health care providers by request.				X
2. Conduct assessment and referral services to pregnant and postpartum women.	X			
3. Conduct a weekly postpartum support group.		X		
4. Conduct a weekly therapeutic yoga group.		X		
5. Seek funding options and a sustainability plan.				X
6. Distribute educational materials.			X	X
7.				
8.				
9.				
10.				

b. Current Activities
Activities from last year continue. Perinatal mood disorder navigator continues to conduct training sessions for health care providers by request and plans. Targeted groups include: Providence Family Support Services staff and Maternity Education Center staff, and Alaska Doulas. She provides assessment and referral services for pregnant and postpartum women who have a history of, or are currently suffering from, mood disorders. She conducts a postpartum support group which meets weekly, as well as a weekly "Mom and Me" therapeutic yoga group.

The Children's Hospital at Providence will not continue to fund the perinatal depression program after December 2009 so the perinatal mood disorder navigator is seeking options for continued funding and a sustainability plan. The WCFH perinatal nurse consultant is attempting to assist in securing funding for future program services and continues to support the project by distributing materials, including through the WCFH perinatal list serve.

c. Plan for the Coming Year
She will continue to conduct training sessions for health care providers and plans to expand training throughout the state. Targeted groups include: Providence Family Support Services staff and Maternity Education Center staff, and Alaska Doulas. She will also continue to facilitate the support group and provide direct counseling services.

The perinatal mood disorder navigator will explore developing a volunteer resource network that would provide respite to postpartum moms. Availability of counseling services as part of an expanded postpartum Medicaid benefit package will be explored as well.

The WCFH perinatal nurse consultant continues to support the project by facilitating professional continuing education opportunities, and distributing materials. Title V will provide funds for reproduction of educational packets as possible.

The long-term future of the perinatal depression program is in question because of lack of funding. The perinatal mood disorder navigator and WCFH are looking for funding opportunities and may collaborate on a grant.

These activities are infrastructure building and enabling services.

State Performance Measure 8: *Prevalence at birth (per 1,000) of Fetal Alcohol Spectrum Disorders (FASD).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			5	1	18
Annual Indicator		1.4	19.3	19.1	16.9
Numerator		41	576	569	505
Denominator		29852	29852	29868	29930
Data Source					AK Birth Defects Registry
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18	17	17	17	17

Notes - 2008
Numerator: Number of reported cases of Fetal Alcohol Spectrum Disorders (FASD) during a consecutive three-year time period.

Denominator: Total number of Alaska-resident live births during a consecutive three-year time period.

Data on the number of children born with Fetal Alcohol Spectrum Disorders (FASD) are based on reports of ICD-9 code 760.71 to the Alaska Birth Defects Registry. Data is presented as 3-year averages - for example, data presented for reporting year 2008 is for children born in 1999-2001.

Since more children wil be diagnosed as they get older, the prevalence for any specific cohort will change year to year. For the reporting year 2009, the prevalence of FASD for children born 2000-2002 is 16.9 (n=505, d=29,930), as of April 2009. The average age of diagnosis for FAS is

5-6 years. Due to the small number of annual events that occur in Alaska, rates are presented for three-year birth cohorts.

Notes - 2007
Data Source: Alaska Bureau of Vital Statistics for the number of live births.

Data on the number of children born with Fetal Alcohol Spectrum Disorders (FASD) are based on reports of ICD-9 code 760.71 to the Alaska Birth Defects Registry.

For each reporting year, prevalence is calculated for several birth cohorts, but only one cohort is shown in the table. For example, data presented for reporting year 2007 is for children born 1998- 2000, as of May 2008.

Since more children will be diagnosed as they get older, the prevalence for any specific cohort will change year to year.

For the reporting year 2008, the prevalence of FASD for children born 1999 - 2001 is 15.4 (n=462, d=29948), as of May 2008.

The average age of diagnosis for FAS is age 5-6 years. Due to the small number of annual events that occur in Alaska, rates are presented for three-year birth cohorts.

Notes - 2006
Data Source: Alaska Bureau of Vital Statistics is the reporting source for the number of live births. Data on the number of children born with Fetal Alcohol Spectrum Disorders (FASD) will be provided based on reports of ICD-9 code 760.71 to the Alaska Birth Defects Registry.

Starting with reporting year 2006, the methodology in measuring this indicator changed. Previously, we measured rates of FAS. In reporting year 2006 and henceforth, we shall be reporting on FASD.

Due to the small number of annual events that occur in Alaska, rates are presented for three-year birth cohorts. Data presented in the FY 2008 block grant, for reporting year 2006, is based on an analysis performed on children born during the years 1997- 1999, as of June 2007.

For the reporting year 2007, the prevalence of FASD for children born 1998 - 2000 is 18.1 (n=542, d=29868), as of June 2007.

The average age of diagnosis for FAS is age 5-6 years. Birth cohorts who are age six in the reporting year (2007) will be included in the numerator.

a. Last Year's Accomplishments
Under the Alaska Birth Defects Registry (ABDR), FAS surveillance activities continued using the CDC FASSNet model. The Epidemiology Unit of WCFH began work on a special edition of the MCH Data Book that will feature FASD data for birth years 1996-2002, the first comprehensive data published since the inception of the surveillance program. Computer programming staff integrated the FASSLink and ABDR databases so that children are linked by a common identifier.

After being vacant for about two years, the ABDR coordinator position was filled. This position is responsible for ABDR oversight and FAS surveillance activities. FAS surveillance used to be a distinct program from the ABDR, with some funding allocated from our Division of Behavioral Health. That funding ended in FY06, however, FAS surveillance activities have continued without interruption. The new coordinator re-established former relationships with FASD service organizations including the state FASD program in the Division of Behavioral Health.

The perinatal nurse continued to meet with public and private health care providers and

administrators at facilities across Alaska to assess perinatal health needs, collaborate on program development, and evaluate efforts. She visited the bush towns of Nome and Kotzebue. In Anchorage, she held the first perinatal advisory committee meeting, attended by 32 health care providers representing a variety of geographic areas, types of facilities, and health care professions. Alcohol use during pregnancy, among other topics, was discussed.

A number of her activities address prenatal care generally. In addition to providing continuing education opportunities for health care providers, a perinatal list serve was started that has been used to share information about evidence-based programs and professional education opportunities, including those related to FASD prevention.

The WCFH Epi Unit continued to conduct MCH outcome data analyses and update MCH publications. Our Alaska MCH Data Book-PRAMS Edition and MCH fact sheets that address multiple issues relevant to perinatal health have been widely circulated to health care providers across the state. The Healthy Mother, Healthy Baby Diary, that includes FASD among other health education topics on pregnancy and infant care, along with other materials furnished through Title V funding, were distributed to a large number of facilities where women seek confirmations of pregnancies, early prenatal care, and give birth.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue funding the ABDR/FAS data surveillance program with the MCH Block Grant.				X
2. Continue FAS data abstraction and data cleaning in preparation for analysis and MCH Data Book publication.				X
3. Develop and distribute interim publications based on FAS data analysis.				X
4. Continue health care provider education regarding alcohol abstinence during pregnancy, including the sharing of prevalence rates of FAS.				X
5. Update and continue distribution across Alaska of the WCFH MCH Fact Sheet on FAS.				X
6. Continue regular distribution of Alaska Birth Defects Monitor, a newsletter that includes FASD.				X
7. Address FASD prevention in preconception committee efforts.				X
8.				
9.				
10.				

b. Current Activities

Under the ABDR, FAS surveillance activities continue using the CDC FASSNet model. ABDR continues medical records abstractions and data cleaning in preparation for the MCH Data Book that will feature 1996-2002 FASD data, the first comprehensive data published since the inception of the surveillance program. Computer programming staff continues to work on ABDR-FASD database integration, and we began evaluation of our FAS surveillance system. The ABDR coordinator presented preliminary FASD data at statewide meetings. An MCH epidemiologist published an Epi Bulletin with birth defects prevalence data, including FASD. A funding request for state general funds to support ABDR-FAS Surveillance activities was submitted as well as an application to CDC for FAS Surveillance. ABDR staff met with staff of the new Arctic FASD Regional Training Center to discuss potential for collaboration. MCH Epi published the Alaska Birth Defects Monitor, a newsletter about birth defects in Alaska, to include FASD.

The perinatal nurse consultant's activities from the past year continue. This year she visited the bush town of Dillingham. The perinatal advisory committee met twice. WCFH convened a preconception committee which will address FASD. The perinatal nurse consultant is exploring options to support expanding early prenatal care referral at facilities that provide pregnancy testing and at pregnancy test point of purchase, including advice to avoid alcohol, tobacco and other substances.

c. Plan for the Coming Year

The special FASD edition of the MCH Data Book and interim publications will be posted on the web and distributed to as many providers of obstetrical and newborn care as possible, as well as other relevant health care providers and service organizations. Findings will be presented to the major health care providers and educators with the hope that improvements in referral rates for at-risk populations will occur. Data may be helpful in determining the distribution of services offered to children with a diagnosis of FASD and assist in assessing where the gaps in services exist. We will continue abstracting medical records for children reported to the ABDR as affected by maternal alcohol use.

WCFH will work collaboratively with the newly established Arctic FASD Regional Training Center in Anchorage to reach health care providers statewide with information about FAS prevalence and high risk populations so that they may better target prevention efforts and be informed about trends over time. MCH Epi will also continue to publish the Alaska Birth Defects Monitor newsletter.

The perinatal nurse consultant will continue to visit sites across Alaska and distribute WCFH-published data and other selected materials, including those on FASD prevention A revision of the Healthy Mother, Healthy Baby Diary, that includes FASD prevention information, will get into full swing in the coming year, in anticipation of a reprinting.

The perinatal advisory committee will meet in person in Fall 2009 and twice by teleconference later in the year. Tentatively, FASD will be the focus of the Spring 2010 meeting. She will continue to pursue options for partnering with other professional organizations, e.g. Alaska Academy of Family Physicians, to provide continuing education on FASD.

WCFH will work with Alaska Division of Behavioral Health to distribute FASD materials and recognize Birth Defects Prevention Month in January. The perinatal nurse consultant will work with the Anchorage FASD coalition to promote and recognize FAS Awareness Day in September.

WCFH will continue to work toward supporting high risk women in the prevention of FASD. Coming up with an affordable, effective home visiting program continues to be of interest, including integration of alcohol, tobacco and other substance cessation interventions.

These are infrastructure building and population-based activities.

State Performance Measure 9: *Percentage of infants who are reported to have a Cleft Lip/Palate defect who access the Title V sponsored Cleft Lip and Palate Specialty Clinic within the first year of life.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			26	27	28
Annual Indicator	27.1	29.2	28.4		
Numerator	19	21	21		

Denominator	70	72	74		
Data Source					
Is the Data Provisional or Final?					
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	30	30	30	30

Notes - 2008
Data wasnot been evaluated for this state performance measure for this year's submission. We are re-evaluating the usefulness of this indicator as a measure effectiveness of our CLP referral process.

Some families do not participate in state-sponsored Cleft Lip and Palate Specialty Clinics even though they have been referred to the clinics. Instead they choose to seek medical care out of state for a variety of reasons (to be near extended family, to access a Craniofacial center closer to their homes than the nearest state-sponsored clinic, to remain within the military healthcare system, or to address other major health problems that cannot be treated at facilities within the state). In addition some children who have cleft palates in conjunction with other life-threatening conditions do not survive long enough to participate in state-sponsored clinics.

Notes - 2007
Data wasnot evaluated for this state performance measure for this year's submission. We are re-evaluating the usefulness of this indicator as a measure effectiveness of our CLP referral process.

Some families do not participate in state-sponsored Cleft Lip and Palate Specialty Clinics even though they have been referred to the clinics. Instead they choose to seek medical care out of state for a variety of reasons (to be near extended family, to access a Craniofacial center closer to their homes than the nearest state-sponsored clinic, to remain within the military healthcare system, or to address other major health problems that cannot be treated at facilities within the state). In addition some children who have cleft palates in conjunction with other life-threatening conditions do not survive long enough to participate in state-sponsored clinics.

Notes - 2006
Sources: 1) AK Birth Defects Registry (ABDR); 2) Alaska Cleft Lip and Palate Specialty Clinics Program

This indicator is presented in 3-year averages. The indicator for reporting year 2006 represents 2004-2006.

This indicator may be updated at a later date. Numbers change because of late reports to the Birth Defects Registry.

a. Last Year's Accomplishments
Cleft lip and palate clinics continued in Anchorage and Fairbanks. Four clinics were held in Anchorage and three in Fairbanks. Anchorage clinics were coordinated by the state Section of Women's, Children's and Family Health, and Fairbanks clinics were coordinated by the Section of Public Health Nursing. There was not a clinic in Bethel as there were barriers identified. Because of the small number of patients from that area, it was decided that the clinic would be held on an as-needed basis. Several client families from the Bethel area preferred traveling to Anchorage for clinic visits because they got other health services there.

Anchorage clinics were held at the Alaska Native Medical Center (ANMC) through a Memorandum of Agreement between the state and Southcentral Foundation (SCF), an Alaska Native-owned healthcare corporation. After many years of one-year agreements, SCF and the state signed a three-year agreement that assures clinics will be held at ANMC through FY10. ANMC providers were interested in housing the clinics at their facility because approximately half

of the children who received evaluations at the state-sponsored clinics were their beneficiaries. Fairbanks clinics were held at the Fairbanks Public Health Center as they have been for many years.

A multidisciplinary team provided patient evaluations. Team members included an audiologist, dietitian, oral surgeon, orthodontist, otolaryngologist, pediatric dentist, pediatrician, plastic surgeon and speech pathologist. In Anchorage and Fairbanks providers from the community volunteered their time and expertise to provide patient evaluations.

A parent navigator from Stone Soup Group participated in all clinics and was available to meet with families who requested her services. Her role was to link parents to resources and improve follow-through of treatment plans to assure optimal outcomes. In addition the parent navigator met with parents of newborns at hospitals before discharge and was available to work with parents of cleft-affected children as needed. She wrote a semi-annual newsletter for parents. Parent navigation services were supported by a grant to Stone Soup Group from the state. The parent navigator averaged eight hours of work per week under the grant.

In an effort to increase capacity, provider training was offered at Anchorage clinics. Pediatric dentistry residents, general dentistry residents, a dietitian and a speech pathologist observed at clinics and shadowed team members from their specialty. They gained an understanding of the special needs of children with orofacial clefts and the importance of a multidisciplinary approach to treatment.
During FY2008 116 children received evaluations at State-sponsored cleft palate clinics. Of these, 11 were new patients who were seen within the first year of life. Most newborn referrals were made by hospitals and/or physicians. In rare instances the parent of a cleft-affected newborn self-referred.

All of these activities were supported by the MCH Block Grant.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Research facilities in the private sector that could be used for state-sponsored clinics in communities where public health centers are not available.				X
2. Work with the Alaska Native Medical Center to continue renting their facility as a site for four Anchorage clinics per year.				X
3. Review need for Cleft Palate Clinic in Bethel and hold clinics as needed and work with local providers to host the clinic.	X	X		X
4. Continue grant with Stone Soup Group for parent navigation services.		X		X
5. Work with public health nurses/tribal organizations to assure that families throughout the state have access to clinic services.			X	
6. Continue providing support to Fairbanks public health center staff and the Cleft Palate Clinic team as needed.				X
7. Work with Birth Defects Registry to assure cleft-affected infants are referred to clinics within the first year of life.				X
8. Provide opportunities for health care professionals to acquire expertise in treating children with orofacial clefts.				X
9. Expand the numbers of hospitals parent navigation services are offered for babies born with cleft lip and palate to assure referral for parent navigation services within one month of life.		X		
10.				

b. Current Activities
Activities conducted last year continue in the current year.

Clinic visits increased in FY09 to 127 (provisional data, waiting for final clinic count for April Fairbanks clinic). The number of new patients who are seen in the first year of life is back up to 24 (also provisional, waiting for Fairbanks April clinic data). There are concerns that some newborns with orofacial clefts are not being referred to State-sponsored cleft palate clinics. In an effort to assure that all are referred and given an opportunity to attend clinics, specialty clinics staff and Birth Defects Registry staff are collaborating on a system for sharing and comparing data. In addition Stone Soup Group is keeping a list of all cleft-affected newborns that are referred to them. They share their information with the state.

The State Oral Health Program is donating a limited number of spin brushes to Cleft Palate Clinics. A pediatric dentist determines which children would most benefit from having the brushes, and those children receive a brush at their clinic visit.

c. Plan for the Coming Year
Work will continue to assure that State-sponsored cleft lip and palate clinics are easily accessible to families throughout Alaska. Clinics will be held in Anchorage and Fairbanks. Bethel families will continue to be invited to attend the Anchorage clinics.

As providers retire or relinquish their positions on the team, new team members will be added. In order to assure there is capacity in the community, training of providers will continue. More than one provider from each specialty will participate in clinics throughout the year so that the responsibility can be shared. Volunteer providers will continue to make up the clinic team.

Data on newborns from the Birth Defects Registry and from Stone Soup Group will be compared with data from clinic referrals to determine if all newborns with orofacial clefts are being referred to State-sponsored clinics. If families are identified that were not referred to clinic, their primary care provider will be educated on the clinic and services provided including parent navigation. Visits to the major hospitals where newborns with cleft lip/palate are born will be inserviced routinely to educate nursing staff on the services available. In addition, a presentation may be done in both Anchorage and Fairbanks at the weekly pediatric grand rounds that pediatric providers attend.

These are direct health care and infrastructure-building services.

E. Health Status Indicators

Introduction
/2010/ MCH Data Books provide Alaskan health care providers, public health program managers, and policy makers with detailed information on health status indicators. Beginning in 2003 and every third year thereafter, the Data Book features a comprehensive look at maternal and child health indicators. In interim years, Data Books focus on specific MCH topics, presenting the findings of public health surveillance programs operated by the MCH Epidemiology Unit. The data books are available online at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/default.htm.

Special Series Fact Sheets are a set of 42 condensed fact sheets addressing prevalence, trends, comparisons to the national baseline, disparities, and interventions and

recommendations on a variety of health topics. The fact sheets have proven useful for providing quick overviews to legislators, the public, and other interested parties, and are also used to develop needs assessments for the MCH population. The fact sheets are online at http://www.epi.hss.state.ak.us/mchepi/MCHFacts/na.htm.

Epidemiology Bulletins are short summaries of research findings or reports from our surveillance activities, distributed to the health care community. These are available online at http://www.epi.hss.state.ak.us/mchepi/pubs/listtype.jsp?type=Bulletin.

The MCH Epidemiology Unit is very active in research and publication in areas that have direct relevance to program evaluation, clinical practice, and understanding risk factors. //2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.0	6.0	5.9	5.7	
Numerator	617	630	652	623	
Denominator	10302	10415	10958	11007	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

Notes - 2007
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

The most recent data available is for CY 2006. CY 2007 data will be available for the FY 2010 submission.

Narrative:
/2010/The proportion of low birthweight, and very low birthweight for all and singleton births dropped from 2006 to 2007. The Healthy People goal for very low birthweight births was met in 2007. The Anchorage/MatSu region had the highest percentage of low birthweight among singleton births. This region is where almost 2/3 of the deliveries occur. The Northern and Southwest regions had the highest percent of preterm births during 2001 - 2005. Prevention of unintended pregnancy and reduction in smoking, other tobacco use, alcohol and other illicit drugs during pregnancy may improve birth outcomes. Prenatal tobacco use, including cigarettes, smokeless tobacco and iq'mik (spit tobacco) is tracked through PRAMS. Women with high risk pregnancies are generally referred to tertiary care centers. Gains in reductions of preterm births in the Alaska Native population have occurred during the time the Indian Health Service has had a

perinatologist on staff at the Alaska Medical Center for the last few years. With his departure in calendar year 2008, it will be interesting to see if the progress made over the years he has been in the state changes. In addition, the state lost a second private sector perinatologist leaving the state with only one for the entire state.//2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.6	4.7	4.7	4.2	
Numerator	462	481	502	449	
Denominator	10007	10147	10649	10699	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

Notes - 2007
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

The most recent data available is for CY 2006. CY 2007 data will be available for the FY 2010 submission.

Narrative:
12010/The proportion of low birthweight, and very low birthweight for all and singleton births dropped from 2006 to 2007. The Healthy People goal for very low birthweight births was met in 2007. The Anchorage/MatSu region had the highest percentage of low birthweight among singleton births. This region is where almost 2/3 of the deliveries occur. The Northern and Southwest regions had the highest percent of preterm births during 2001 - 2005. Prevention of unintended pregnancy and reduction in smoking, other tobacco use, alcohol and other illicit drugs during pregnancy may improve birth outcomes. Prenatal tobacco use, including cigarettes, smokeless tobacco and iq'mik (spit tobacco) is tracked through PRAMS. Women with high risk pregnancies are generally referred to tertiary care centers. Gains in reductions of preterm births in the Alaska Native population have occurred during the time the Indian Health Service has had a perinatologist on staff at the Alaska Medical Center for the last few years. With his departure in calendar year 2008, it will be interesting to see if the progress made over the years he has been in the state changes. In addition, the state lost a second private sector perinatologist leaving the state with only one for the entire state.//2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.2	0.9	1.1	0.9	
Numerator	119	95	123	99	
Denominator	10302	10415	10958	11007	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

Notes - 2007
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

The most recent data available is for CY 2006. CY 2007 data will be available for the FY 2010 submission.

Narrative:
/2010/The proportion of low birthweight, and very low birthweight for all and singleton births dropped from 2006 to 2007. The Healthy People goal for very low birthweight births was met in 2007. The Anchorage/MatSu region had the highest percentage of low birthweight among singleton births. This region is where almost 2/3 of the deliveries occur. The Northern and Southwest regions had the highest percent of preterm births during 2001 - 2005. Prevention of unintended pregnancy and reduction in smoking, other tobacco use, alcohol and other illicit drugs during pregnancy may improve birth outcomes. Prenatal tobacco use, including cigarettes, smokeless tobacco and iq'mik (spit tobacco) is tracked through PRAMS. Women with high risk pregnancies are generally referred to tertiary care centers. Gains in reductions of preterm births in the Alaska Native population have occurred during the time the Indian Health Service has had a perinatologist on staff at the Alaska Medical Center for the last few years. With his departure in calendar year 2008, it will be interesting to see if the progress made over the years he has been in the state changes. In addition, the state lost a second private sector perinatologist leaving the state with only one for the entire state.//2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0.8	0.8	0.9	0.6	
Numerator	79	80	96	66	
Denominator	10007	10147	10649	10699	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

Notes - 2007
Source: AK Bureau of Vital Statistics. The latest available data is for 2007.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

The most recent data available is for CY 2006. CY 2007 data will be available for the FY 2010 submission.

Narrative:
/2010/ The proportion of low birthweight, and very low birthweight for all and singleton births dropped from 2006 to 2007. The Healthy People goal for very low birthweight births was met in 2007. The Anchorage/MatSu region had the highest percentage of low birthweight among singleton births. This region is where almost 2/3 of the deliveries occur. The Northern and Southwest regions had the highest percent of preterm births during 2001 - 2005. Prevention of unintended pregnancy and reduction in smoking, other tobacco use, alcohol and other illicit drugs during pregnancy may improve birth outcomes. Prenatal tobacco use, including cigarettes, smokeless tobacco and iq'mik (spit tobacco) is tracked through PRAMS. Women with high risk pregnancies are generally referred to tertiary care centers. Gains in reductions of preterm births in the Alaska Native population have occurred during the time the Indian Health Service has had a perinatologist on staff at the Alaska Medical Center for the last few years. With his departure in calendar year 2008, it will be interesting to see if the progress made over the years he has been in the state changes. In addition, the state lost a second private sector perinatologist leaving the state with only one for the entire state.//2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	17.6	19.1	19.4	20.1	
Numerator	85	92	93	97	
Denominator	481844	480546	480464	482503	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2007 covers 2005 - 2007. The latest available data is 2005-2007.

Notes - 2007
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2007 covers 2005 - 2007. The latest available data is 2005-2007.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

This indicator is expressed in 3 year averages (2006 covers 2004-2006). The most recent data covers 2004- 2006. Data for 2007 will be available for the FY 2010 block grant application.

Narrative:
/2010/Unintentional injury is the leading cause of mortality among all children in Alaska and the nation. Alaskans frequently participate in activities that could put children at risk for unintentional injury. The Childhood Understanding Behaviors Survey surveillance program tracks risk factors. Fifty-nine percent of Alaska two-year olds in 2006 had ridden in a boat since birth and 18% rode on, or were pulled in a trailer behind, an ATV or snow machine during the past week. The second leading cause of unintentional injury among adolescents is drowning. This type of information can be used for targeted messaging.

Injury prevention programs are implemented by the Division of Public Health, Section of Injury Prevention and Emergency Medical Services (IPEMS). Two examples are:

The Alaska Kids Don't Float program is aimed at preventing drowning, the second leading cause of mortality among children under 14. The program includes a personal floatation device loaner program for use at harbors and boat ramps, water safety 'train the trainers' education for high school students, and public education throughout the state of Alaska with a focus in high use areas and rural river systems used for transportation in bush Alaska.

An injury prevention home visitation program. The objective is to educate home visiting groups of unintentional injuries and related hazards in the home, then train the home visitors to perform home safety reviews, provide home safety education, and install safety devices to high-risk households. Training is provided to any interested groups, such as Headstart, or Village Health Aides, on home safety inspections and the installation of safety devices.

IPEMS partners with the Safe Kids Alaska on a variety of events such as car seat checkups, Safe Routes to School, and Safety Bear.

The Section Chief of IPEMS and the MIMR/CDR epidemiologist traveled to the national conference on childhood injury prevention in May 2009. By working together during the conference, they formulated a plan to work more closely together on data reporting and prevention strategies to reduce the incidence of child injuries. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	5.8	6.5	5.0	4.1	
Numerator	28	31	24	20	
Denominator	481844	480546	480464	482503	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2007 covers 2005 - 2007. The latest available data is 2005-2007.

Notes - 2007
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2007 covers 2005 - 2007. The latest available data is 2005-2007.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

This indicator is expressed in 3 year averages (2006 covers 2004-2006). The most recent data covers 2004- 2006. Data for 2007 will be available for the FY 2010 block grant application.

Narrative:
/2010/ The unintentional injury mortality rate for children < 14 years due to motor vehicle crashes dropped for the second year in a row (based on 3-year moving averages). The Child Passenger Safety Program, implemented by Section of Injury Prevention and Emergency Medical Services (IPEMS) (http://www.hss.state.ak.us/dph/ipems/injury_prevention/CPS/default.htm) offers information on safety restraints, legislation, and other programs in Alaska.

In 2009 the legislature passed new legislation requiring the use of booster seats for young children and clarified the use of child passenger restraints based on the national standards. This will hopefully make the management of these information to the public more easily understood and will assist law enforcement with enforcing the laws. The challenge is that there are many motor vehicle deaths in the rural parts of the state where child passenger safety seats are not used due to alternative methods of travel such as three and four wheelers. Ongoing education and modeling by adults is needed in order to change long standing behaviors.//2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	27.5	26.9	21.6	24.9	
Numerator	78	78	64	75	
Denominator	283914	290239	296409	301774	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2007 covers 2005 - 2007. The latest available data is 2005-2007.

Notes - 2007
Source: AK Bureau of Vital Statistics. This indicator is reported as a 3-year moving average, 2007 covers 2005 - 2007. The latest available data is 2005-2007.

Notes - 2006
Source: Alaska Bureau of Vital Statistics

This indicator is expressed in 3 year averages (2006 covers 2004-2006). The most recent data covers 2004- 2006. Data for 2007 will be available for the FY 2010 block grant application.

Narrative:
/2010/ In the last decade, approximately 42% of deaths among Alaskan teens were due to unintentional injury, with more than half of those caused by motor vehicle crashes.

Effective January 1, 2005, drivers under 18 years of age may only have a provisional license with proof of 40 hours of driving experience, including 10 in challenging conditions. Provisional license drivers may not carry passengers under the age of 21, except siblings, and may not operate a motor vehicle between 1:00 am and 5: 00 am, unless accompanied by an adult over 21 or driving to work. This law has helped to reduce some of the injuries of children in this age group in the urban areas of the state, however has not necessarily impacted areas of the state where alternative vehicles are used for transportation due to the last of hard surface roads. It is common for young children to operate 3 and 4 wheelers without helmets or adults accompanying them in rural parts of state. Ongoing education and appropriate modeling and supervision by adults is needed to change these behaviors.//2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	349.0	338.8	303.4	417.1	
Numerator	559	543	486	674	
Denominator	160155	160249	160168	161580	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Trauma Registry. The latest available data is for 2007.

Notes - 2007
Source: AK Trauma Registry. The latest available data is for 2007.
HSI 4A is calculated using all nonfatal unintentional hospitalized injuries for children 14 years old or younger. Ecode < 950.0

Notes - 2006
Source: Alaska Trauma Registry

/2008/ Data is reported by calendar year. The most recent data available is CY2006. The 2007 estimate will be available for the 2010 block grant application.

HSI 4A is calculated using all nonfatal unintentional hospitalized injuries for children 14 years old or younger. Ecode < 950.0

Narrative:
/2010/ Unintentional injury is the leading cause of mortality among all children in Alaska and the nation. Alaskans frequently participate in activities that could put children at risk for unintentional injury. The Childhood Understanding Behaviors Survey surveillance program tracks risk factors. Fifty-nine percent of Alaska two-year olds in 2006 had ridden in a boat since birth and 18% rode on, or were pulled in a trailer behind, an ATV or snow machine during the past week. The second leading cause of unintentional injury among adolescents is drowning. This type of information can be used for targeted messaging and education.

Injury prevention programs are implemented by the Division of Public Health, Section of Injury Prevention and Emergency Medical Services (IPEMS). Two examples are:

 # The Alaska Kids Don't Float program is aimed at preventing drowning, the second leading cause of mortality among children under 14. The program includes a personal floatation device loaner program for use at harbors and boat ramps, water safety 'train the trainers' education for high school students, and public education.

 # An injury prevention home visitation program. The objective is to educate home visiting groups of unintentional injuries and related hazards in the home, then train the home visitors to perform home safety reviews, provide home safety education, and install safety devices to high-risk households. Training is provided to any interested groups, such as Headstart, or Village Health Aides, on home safety inspections and the installation of safety devices.

Bike helmet safety is also a heavily promoted intervention with the Safe Kids Alaska sites hosting annual bike rodeos every spring/summer to promote bicycle safety and helmet usage. Finally, helmet usage by children on snow machines has been promoted annually in the larger rural communities who depend upon snow machines for transportation.

IPEMS partners with the Safe Kids Alaska on a variety of events such as car seat checkups, Safe Routes to School, and Safety Bear.

The Section Chief of IPEMS and the MIMR/CDR epidemiologist traveled to the national conference on childhood injury prevention in May 2009. By working together during the conference, they formulated a plan to work more closely together on data reporting and prevention strategies to reduce the incidence of child injuries.//2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	41.3	15.0	5.6	22.9	
Numerator		24	9	37	
Denominator		160249	160168	161580	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Trauma Registry. The latest available data is for 2007.

Notes - 2007
Source: AK Trauma Registry. The latest available data is for 2007.
HSI 4B is calculated using hospitalizations for nonfatal injuries due to motor vehicle crashes on the highway incl. bike and pedestrian vs motor vehicles: ecodes 810.0 - 819.9

Notes - 2006
Source: Alaska Trauma Registry

/2009/ Data is reported by calendar year. The most recent data available is CY2006. The 2007 estimate will be available for the 2010 block grant application.

HSI 4B is calculated using hospitalizations for nonfatal injuries due to motor vehicle crashes on the highway incl. bike and pedestrian vs motor vehicles: ecodes 810.0 - 819.9

Narrative:
/2010/ The Child Passenger Safety Program, implemented by Section of Injury Prevention and Emergency Medical Services (IPEMS) (http://www.hss.state.ak.us/dph/ipems/injury_prevention/CPS/default.htm) offers information on safety restraints, legislation, and other programs in Alaska. The 2008 Alaska State Legislature amended an existing law relating to use of child safety seats and seat belts to be more specific about using age, height and weight appropriate safety equipment. The law is effective 9/1/2009. IPEMS offers ongoing child passenger safety seat training across the state and has developed a core group of highly experienced trainers located in several communities across the state including some of the larger rural communities. The IPEMS web site offers information on choosing the correct size of safety seat for children and other information on installation and safety features on various brands of car seats/booster seats.//2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Indicator	192	54.8	12.9	161.0	
Numerator		54	13	164	
Denominator		98630	101010	101862	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
Source: AK Trauma Registry. The latest available data is for 2007.

Notes - 2007
Source: AK Trauma Registry. The latest available data is for 2007.

Although the indicator reported for 2007 looks to be in error because of the magnitude of the difference from 2005 and 2006, actually the latter two years were the anamoly. Rates for 2000 through 2004 were: 166.3, 209.1, 182.0, 192.0, and 176.5.

Notes - 2006
Source: Alaska Trauma Registry

/2008/ Data is reported by calendar year. The most recent data available is CY2004. The 2005 estimate will be available for the 2009 block grant application.

HSI 4C is Calculated using hospitalizations for nonfatal injuries due to motor vehicle crashes on the highway incl. bike and pedestrian vs motor vehicles: ecodes 810.0 - 819.9

Narrative:
/2010/ Effective January 1, 2005, drivers under 18 years of age may only have a provisional license with proof of 40 hours of driving experience, including 10 in challenging conditions. Provisional license drivers may not carry passengers under the age of 21, except siblings, and may not operate a motor vehicle between 1:00 am and 5: 00 am, unless accompanied by an adult over 21 or driving to work.//2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	38.7	41.4	40.8	42.1	39.9
Numerator	1014	1084	1105	1138	1080
Denominator	26177	26177	27057	27017	27042
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: AK DHSS, Section of Epidemiology

Notes - 2007
Source: AK Section of Epidemiology

Notes - 2006
Source: AK DHSS, Section of Epidemiology

Narrative:
/2010/ Alaska has had the first or second highest Chlamydia trachomatis (CT) infection rate in the United States each year since 2000. In 2007, the highest documented CT rates were among females aged 15--19 and 20--24 years (4,212 and 5,210 per 100,000 persons, respectively).

The state's STD Program consists of case surveillance, consultation on laboratory and medical aspects of diagnosis and treatment; direct assistance to providers in outbreak situations; assistance to affected individuals and their sexual partners, as well as to their health care providers, with partner notification and access to STD treatment; training for health care providers in partner interviewing, follow up, notification, and referral techniques; and provision of information, technical assistance, and other capacity building services to medical and other health service providers, as well as educators and members of the public. The Title V program actively participates in the Infertility Prevention project as a part of the Title X Family Planning to promote prevention of sexually transmitted infections, access to testing both the client and any partner contacts as well as just in time treatment.

The 2008 chlamydia report is available at http://www.epi.hss.state.ak.us/bulletins/docs/b2009_13.pdf //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	13.9	15.3	16.4	18.2	18.2
Numerator	1582	1750	1872	2075	2074
Denominator	114034	114034	113850	113793	113738
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: AK DHSS, Section of Epidemiology

Notes - 2007
Source: AK Section of Epidemiology

Notes - 2006
Source: AK DHHS, Section of Epidemiology

Narrative:
/2010/ Alaska has had the first or second highest Chlamydia trachomatis (CT) infection rate in the United States each year since 2000.

The state's STD Program consists of case surveillance, consultation on laboratory and medical aspects of diagnosis and treatment; direct assistance to providers in outbreak situations; assistance to affected individuals and their sexual partners, as well as to their health care providers, with partner notification and access to STD treatment; training for health care providers in partner interviewing, follow up, notification, and referral techniques; and provision of information, technical assistance, and other capacity building services to medical and other health service providers, as well as educators and members of the public. The Title V program actively participates in the Infertility Prevention project as a part of the Title X Family Planning to promote prevention of sexually transmitted infections, access to testing both the client and any partner contacts as well as just in time treatment.

The 2008 chlamydia report is available at http://www.epi.hss.state.ak.us/bulletins/docs/b2009_13.pdf //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	11139	6192	403	2508	459	114	1463	0
Children 1 through 4	43862	25965	1406	9104	1758	368	5261	0
Children 5 through 9	53342	33760	2194	10067	1987	359	4975	0
Children 10 through 14	53237	34332	2075	9928	2162	400	4340	0
Children 15 through 19	55609	35715	1937	11262	2152	454	4089	0
Children 20 through 24	46253	28252	2618	9705	1940	375	3363	0
Children 0 through 24	263442	164216	10633	52574	10458	2070	23491	0

Notes - 2010

Narrative:

/2010/ Alaska Native children compose the largest minority among children 0 -- 24 years of age, at 20%. Alaska Native children represent 23% of all infants under 1 year. African-American and Hispanic children together make up 10% of the 0-24 age group.

Population estimates by race and age are made annually by the AK Department of Labor and Workforce Development. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	10353	786	0
Children 1 through 4	40208	3654	0
Children 5 through 9	49937	3405	0
Children 10 through 14	50285	2952	0
Children 15 through 19	53111	2498	0
Children 20 through 24	43179	3074	0
Children 0 through 24	247073	16369	0

Notes - 2010

Narrative:
/ 2010/ Alaska Native children compose the largest minority among children 0 -- 24 years of age, at 20%. Alaska Native children represent 23% of all infants under 1 year. African-American and Hispanic children together make up 10% of the 0-24 age group. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	32	11	2	16	3	0	0	0
Women 15 through 17	243	91	18	109	19	0	0	6
Women 18 through 19	845	383	50	332	53	6	0	21
Women 20 through 34	8586	5373	343	2070	591	39	0	170
Women 35 or older	1343	885	38	247	127	6	0	40
Women of all ages	11049	6743	451	2774	793	51	0	237

Notes - 2010

Narrative:
/2010/ In 2007, the highest birth rates were among women 25 - 29 years (154.2 per 1,000 female population), followed by 20 - 24 (144.1) and 30 - 34 (94.3). Program staff collaborated with the Division of Public Assistance in using TANF funds for providing long acting reversible contraceptives in western Alaska, the region with the highest rate of teen births and non-marital births. These monies have also supported Title V staff in providing education, training and supplies to rural providers on insertion of long acting reversible contraceptives, education on other methods and approaches to family planning education especially for the rural tribal health aides.

The Perinatal Advisory Committee and the newly formed Preconception Advisory Committee, staffed by WCFH and other staff from the Division of Public Health, meet on a regular basis to address issues, needs, and programs.

There is a relatively small Hispanic population in Alaska. The primary criteria for identifying racial disparity is Alaska Native status. Numbers for other minority groups are too small for analysis purposes. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	25	5	2
Women 15 through 17	218	19	6
Women 18 through 19	755	38	22
Women 20 through 34	7938	533	115
Women 35 or older	1254	70	19
Women of all ages	10190	665	164

Notes - 2010

Narrative:
/2010/ There is a relatively small Hispanic population in Alaska. The primary criteria for identifying racial disparity is Alaska Native status. Numbers for other minority groups are too small for analysis purposes. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	72	29	3	35	5	0	0	0
Children 1	10	4	0	5	1	0	0	0

through 4								
Children 5 through 9	13	5	1	6	1	0	0	0
Children 10 through 14	15	6	1	7	0	0	0	1
Children 15 through 19	52	24	2	24	2	0	0	0
Children 20 through 24	79	40	6	29	2	0	0	2
Children 0 through 24	241	108	13	106	11	0	0	3

Notes - 2010

Narrative:
/2010/ The Alaska Maternal Infant Mortality Review (MIMR) has existed since 1991 and is managed by the MCH Epidemiology Unit. Data from the MIMR has enabled research projects that resulted in continued improvements to the public health care system. During the fifteen year period from 1990 to 2004, post-neonatal mortality decreased by 37% and neonatal mortality decreased by 32%. MIMR data was used to implement a Safe Sleep Initiative. Bed sharing, a common practice in Alaska, is an environment frequently involved in infant death. Vital records, medical records, autopsy reports, and first responder reports were analyzed for 93% of Alaskan infant deaths occurring during 1992-2004. Deaths while bed sharing were examined for risk factors including sleeping with a non-caregiver, prone position, maternal tobacco use, impairment of a bed sharing partner, and unsafe sleep surface. The state has established a Safe Sleep Initiative to further clarify its recommendations and target public education messages to families engaging in high risk behaviors. In 2007 the MIMR was expanded to include review of child deaths.

In 2007, the MCH Epidemiology Unit established the Alaska Surveillance of Child Abuse and Neglect (SCAN), an on-going systematic collection and unification of data from up to 9 sources housed in different state agencies. Linking data from a wide variety of sources will allow the state to measure and understand maltreatment-related deaths. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	66	5	1
Children 1 through 4	10	0	0
Children 5 through 9	13	0	0
Children 10 through 14	15	0	0
Children 15 through 19	50	1	1
Children 20 through 24	76	2	1
Children 0 through 24	230	8	3

Notes - 2010

Narrative:
/2010/ There is a relatively small Hispanic population in Alaska. The primary criteria for identifying racial disparity is Alaska Native status. Numbers for other minority groups are too small for analysis purposes. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	217189	135964	8015	42869	8518	1695	20128	0	2007
Percent in household headed by single parent	30.0	22.0	1.0	1.0	1.0	1.0	1.0	1.0	2008
Percent in TANF (Grant) families	5.2	3.4	13.4	5.0	13.5	32.8	4.9	0.0	2008
Number enrolled in Medicaid	154836	79911	30129	33948	5595	2893	0	2360	2008
Number enrolled in SCHIP	15663	6467	873	4919	1246	657	0	1501	2008
Number living in foster home care	2201	602	112	1232	13	24	188	30	2008
Number enrolled in food stamp program	45888	13599	2366	20476	2483	1547	3747	1670	2008
Number enrolled in WIC	27956	11359	1175	8106	926	1245	5117	28	2008
Rate (per 100,000) of juvenile crime arrests	5443.0	2259.0	400.0	1790.0	148.0	93.0	414.0	339.0	2008
Percentage of high school drop-outs (grade 9 through 12)	7.2	5.1	9.6	11.7	6.9	0.0	8.7	0.0	2007

Notes - 2010
Source: KidsCount, Population and Family Characteristics. Electronic References. Retrieved March 16 2009 from http://www.kidscount.org/datacenter/profile_results.jsp?r=3&d=1&c=9&p=5&x=138&y=4

Data is suppressed for all race categories except white non-hispanic, due to small numbers. Estimates based on 2007.

The data is for referrals, not arrests. A referral is counted as a single episode or event and may relate to multiple charges. Referrals by race is for ages 0 - 18+. The denominator is a count of children 0 - 19. The latest available data for the denominator (children by race category) is for the previous year.

Asian and Pacific Islander are counted as one racial group.

Source: Data source: AFCARS Foster Care Submission files. Records were counted if child not discharged last day of reporting period. This is a point in time count, for 9/30/2008.

Narrative:
/2010/ The Alaska Maternal Child Health Data Book 2008: Health Status Edition was published and disseminated in spring 2009. Wherever possible, indicators in this edition were stratified by Alaska Native racial status and by six geographic regions, to explore racial, urban/rural, and health delivery system differences. New indicators that reflect Alaska-specific issues were included, such as bed sharing, infant discharge from hospital within 48 hours, infant checkup within 48 hours, and life stressors among women recently delivering a live birth. All the data books are online at http://www.epi.hss.state.ak.us/mchepi/mchdatabook/default.htm

The Section of Women's Children's and Family Health also main a series of 42 Fact Sheets on health status of women, children, and children with special health care needs. These fact sheets are distributed widely to health care providers, legislators, and the general public, and will be used for the Title V Needs Assessment in 2010. They are updated on a regular basis with data from our six surveillance projects and extensive research activities. They are available online at http://www.epi.hss.state.ak.us/mchepi/MCHFacts/na.htm. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	203894	13295	0	2007
Percent in household headed by single parent	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	5.4	4.4	0.0	2008
Number enrolled in Medicaid	76532	3379	0	2008
Number enrolled in SCHIP	14738	925	0	2008
Number living in foster home care	1936	101	164	2008
Number enrolled in food stamp program	44158	1730	0	2008
Number enrolled in WIC	25524	2404	28	2008
Rate (per 100,000) of juvenile crime arrests	2588.0	1249.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	6.8	5.2	0.0	2007

Notes - 2010
Source: KidsCount, Population and Family Characteristics. Data is suppressed for all race categories except white non-hispanic, due to small numbers. Estimates based on 2007.

Electronic References. Retrieved March 16 2009 from http://www.kidscount.org/datacenter/profile_results.jsp?r=3&d=1&c=9&p=5&x=138&y=4

Students of mixed ethnicity was included in the Not Hispanic or Latino category.

Narrative:
/2010/ There is a relatively small Hispanic population in Alaska. The primary criteria for identifying racial disparity is Alaska Native status. Numbers for other minority groups are too small for analysis purposes.//2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	96596
Living in urban areas	143068
Living in rural areas	75029
Living in frontier areas	0
Total - all children 0 through 19	218097

Notes - 2010

Narrative:
/2010/ Approximately 75% of Alaskan communities, including the state's capital city of Juneau, are not connected to the road system, although 3 out of 4 Alaskans live in or near Anchorage, Fairbanks or Juneau. The concentration of children in the remote rural population, especially Native children and in smaller communities outside the regional centers, is striking.

The geographic isolation of rural communities means significant challenges in assuring all MCH populations have access to routine preventive care, acute medical and specialty care. Accessing "nearby health services" or specialized health care means travel by commercial jet, small plane, the state marine ferry system, all terrain vehicles, small boats or snow machines. Some residents may travel distances equivalent to traveling from Washington, D.C. to New Orleans for even routine medical care. Moreover, severe weather can render travel impossible, creating especially critical situations in medical emergencies. Even if ideal health care systems were in place, socio/economic factors create additional barriers for populations living in frontier and remote areas. Compared to urban populations, frontier and remote populations are poorer, lack health insurance, have limited employment opportunities and face cultural or language barriers.

Significant improvements in the health status of natives have been made since the 1970s as a result of investments in village sanitation, housing, and access to health care services and facilities.
The addition of federally funded community health centers is also thought to have contributed to improvements in health for women and children, although services for

these populations are limited by skill, access to supplies and frequent provider turnover. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	659004.0
Percent Below: 50% of poverty	4.5
100% of poverty	10.4
200% of poverty	25.9

Notes - 2010
Population for whom poverty status is determined

Narrative:
/2010/ Rural areas of Alaska have few full-time job opportunities and therefore poverty levels tend to be higher there. Rural residents continue to depend on subsistence hunting and fishing, and incomes are low. Alaska Natives are moving from villages to urban areas for jobs and education opportunities and this may result in higher standards of living, over time, for those families who make the transition. However, the population of remote villages continue to grow despite migration to urban areas
The Alaska Permanent Dividend continues to be an important source of cash income for many families. It was estimated that without the dividends, twice as many Anchorage residents would have fallen below the federal poverty line in 2000. In 1999, when dividends were close to $2,000 per person, they made up to 15% of per capita income in the Wade Hampton Census Area which has the lowest incomes in the state.

(Source: "Understanding Alaska: People, Economy, and Resources". Institute of Social and Economic Research, University of Alaska Anchorage, 2006). //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	218097.0
Percent Below: 50% of poverty	4.0
100% of poverty	11.0
200% of poverty	31.0

Notes - 2010

Narrative:
/2010/ The Alaska Permanent Dividend continues to be an important source of cash income for many families. It was estimated that without the dividends, twice as many Anchorage residents would have fallen below the federal poverty line in 2000. In 1999,

when dividends were close to $2,000 per person, they made up to 15% of per capita income in the Wade Hampton Census Area which has the lowest incomes in the state.

(Source: "Understanding Alaska: People, Economy, and Resources". Institute of Social and Economic Research, University of Alaska Anchorage, 2006). //2010//

F. Other Program Activities

Calls to the toll-free hotline is automatically directed to main telephone line at the Section of Women's, Children's and Family Health. The hotline is available within Alaska and outside of Anchorage only, in accordance with the state's policy on toll-free numbers. It is not possible to document the number of calls that are made specifically from the toll-free number. The telephone is staffed during normal business hours and a voice message option is available./2009/ 308 calls were recored for SFY08 to the hotline number. Calls are recorded and catagorized based on which program or issuesthe caller is inquiring about. This number does not include all of the calls requresting assistance for Medicaid Services, WIC, physician assistance. Approximately 50 calls per day come into the main/toll free number. //2009//

/2010/ The Toll free hotline is combined with the main number for the Title V/CSHCN program. Approximately 20 calls per day come into this number with most callers requesting to talk with one of the staff members. A total of 325 calls were received for state fiscal year 2009 requesting information on specific programs or looking for information regarding services such as WIC, Medicaid, services for children with autism, genetic conditions, breastfeeding, family planning and breast and cervical health check information. The Department of Health and Social Services collaborates with the United Way agency in support of the 211 information systems for the state of Alaska. Specific calls regarding services delivered by agencies are not tracked.//2010//

The MCH-Epidemiology Unit published numerous reports, bulletins and peer-reviewed journal articles. A partial list follows:

Perham-Hester KA, Wiens HN, Schoellhorn J. Alaska Maternal and Child Health Data Book 2004: PRAMS Edition. Anchorage, AK: Maternal and Child Health Epidemiology Unit, Section of Women's, Children's and Family Health, Division of Public Health. September 2005.

Schoellhorn KJ, Beery AL. Alaska Maternal and Child Health Data Book 2005: Birth Defects Surveillance Edition. Anchorage, AK: Maternal and Child Health Epidemiology Unit, Section of Women's, Children's and Family Health, Division of Public Health. May 2006.

Gessner BD. Reproductive health, criminal activity, and abuse among Medicaid-enrolled females age 10 to 15 years. Obstet Gynecol. In Print

Chimonas MA, Baggett HC, Parkinson AJ, Muth PT, Dunaway E, Gessner BD. Asymptomatic Helicobacter pylori Infection and Iron Deficiency are Not Associated With Decreased Growth Among Alaska Native Children Aged 7--11 Years. Helicobacter 2006 Jun;11(3):159-67

Gessner BD, Baggett HC, Muth PT, Dunaway E, Gold BD, Feng Z, Parkinson AJ. A Controlled, Household-Randomized, Open-Label Trial of the Effect That Treatment of Helicobacter pylori Infection Has on Iron Deficiency in Children in Rural Alaska J Infect Dis. 2006;193(4)

Epidemiology Bulletin, Recommendations and Reports. The Educational Attainment of Children with Fetal Alcohol Syndrome. Section of Epidemiology, Alaska Division of Public Health. Vol. 2,

Number 3.

Baggett HC, Parkinson AJ, Muth PT, Gold BD, Gessner BD. Endemic Iron Deficiency Associated With Helicobacter pylori Infection Among School-Aged Children in Alaska Pediatrics 2006;117;396-404;

Epidemiology Bulletin. Summary Report: Reproductive Health Claims and Risk of Abuse among Medicaid-enrolled Adolescent Females. Section of Epidemiology, Alaska Division of Public Health. 2006:1

Gessner BD. Preterm birth in Alaska 1989-2003. Electronic Newsletter: Northwest Bulletin 2006;20:13-14

Gessner BD, Porter TJ. Bed Sharing With Unimpaired Parents Is Not an Important Risk for Sudden Infant Death Syndrome: In Reply Pediatrics 2006;117;994-996

Epidemiology Bulletin, Recommendations and Reports. The Association Between Reproductive Health-Related Medical Claims and Criminal Activity or the Experience of Abuse among Medicaid-enrolled Adolescent Females. Section of Epidemiology, Alaska Division of Public Health. Vol. 10, Number 1.

Epidemiology Bulletin, Recommendations and Reports. Prevention of Perinatal Group B Streptococcal Disease: National Guidelines and a Review of Alaska Early-Onset Neonatal Cases, 2000-2004. Section of Epidemiology, Alaska Division of Public Health. Vol. 9, Number 2.

/2009/ New publications for 2008 are:

Gessner, B. D. (2008). "The effect of Alaska's home visitation program for high-risk families on trends in abuse and neglect." Child Abuse Negl 32(3): 317-33.

Gessner, B. D. (2008). "Lack of piped water and sewage services is associated with pediatric lower respiratory tract infection in Alaska." J Pediatr 152(5): 666-70.

Gessner, B. D. and M. A. Chimonas (2007). "Asthma is associated with preterm birth but not with small for gestational age status among a population-based cohort of Medicaid-enrolled children <10 years of age." Thorax 62(3): 231-6.

Gessner, B. D., E. R. Sedyaningsih, et al. (2008). "Vaccine-preventable haemophilus influenza type B disease burden and cost-effectiveness of infant vaccination in Indonesia." Pediatr Infect Dis J 27(5): 438-43.

Gessner B, Utermohle C. Asthma in Alaska: 2006 Report. Alaska Dept. of Health and Social Services, Division of Public Health, Maternal-Child Health Epidemiology Unit. 2007.

Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. Prenatal Smokeless Tobacco and Iq'mik Use in Alaska. Bulletin No. 28. October 10, 2007.

Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. Preterm Birth Trends - Alaska, 1989-2006. No. 12. May 2, 2008.

Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. Prevalence of Attention Deficit Hyperactivity Disorder among Medicaid Recipients Less Than 20 Years of Age. No. 34. November 5, 2007.

Alaska Department of Health & Social Services, Division of Public Health, Section of

Epidemiology. Findings of the alaska Maternal-Infant Mortality Review 1992-2001. No. 10. June 30, 2006.

Alaska Department of Health and Social Services, Maternal and Child Health Epidemiology. Title V Special Series Fact Sheet, updates:
Sexually Transmitted Diseases and HIV among Women in Alaska. (2:20). July 2007.
Low Birthweight and Preterm Births in Alaska. (2:5). June 2007.
Birth Defects among Infants and Children in Alaska. (1:11). June 2007.
Prenatal Care in Alaska. (1:12). May 2007.
Infant and Fetal Mortality in Alaska. (2:3). June 2007.
Breastfeeding in Alaska. (2:2). May 2007.
Infant and Fetal Mortality in Alaska. (2:3). June 2007.

//2009//

//2010// An updated list of publications is attached.
An attachment is included in this section.

G. Technical Assistance

/2006/ A request for technical assistance has bee submitted requesting funds to have one or two MCH staff attend the National Network of State Adolescent Health Coordinators. This meeting will provide an opportunity to lean what other federal agencies and states are doing in the area of adolescent health and to network with other states that may have limited or no funds for adolescent health coordinators, and to provide input into future directions, i.e. the natioal inititiative to improve adolescent health. The estimated cost for one person to travel would be $1600 from Alaska. We feel this important to stay in touch with other states and their adolescent program and stay abreast of potential funding opportunities as no funding exists at the present time for the state of Alaska to have an adolescent health care coordinator //2006//.

/2007/ A request for technical assistance from the Center for cultural competence has been submitted on form 15. An assessment of our programs for meeting cultural competence could then be utilized in assessing areas of greatest need and assist Alaska's Title V program in developing a plan of improvement with measurable outcomes.//2007//

/2009/ requests for technical assistance have been submitted on form 15.

V. Budget Narrative

A. Expenditures

/2006/ As is noted on forms 3, 4, and 5 of the application, the amount of funds expended in FY04 were less than budget due to the effects of the reorganization and the absorption of many expenses especially in the personnel category by the Division of Health Care Services (a.k.a Medicaid). A significant portion of General funds were supplanted with federal and state match dollars specifically.

As a result of the reorganization of DHSS, programs that had been part of the Section of Maternal, Child and Family Health were distributed to 5 divisions and a significant portion of general fund dollars and Medicaid school base funding went away. As a result, many positions were lost and programs were either cut, absorbed into other programs or were stopped. Specifically funding for Adolescent health, pregnancy prevention, MIMR, family nutrition, and injury prevention was lost. In addition with the distribution of programs to divisions other than where the Title V/CSHCN director is, the oversight of other federal grant programs and state G.F. was eliminated which affected the changes in reported expenditures.

With the reorganization that has gone into effect for FY06, many of the MCH program are being reformulated into the Section of Women's, Children's and Family Health and staff in those programs have been transferred back into the Division of Public Health. With that change comes a financial management team that is much more accustomed to working with federal grants and detailed reporting using ledger codes and other accounting structures related to grant management//2006//.

/2007/ Spending for FY05 occurred closer to budget for FY05 as noted on forms 3, 4, and 5 and was closer to amounts experienced prior to the reorganization in FY03. Categorical spending was much greater in the pregnant women level than anticipated due improved tracking and increase of expenditures from state funds in this arena. This is also true of funding for Children 1-22 years of age. Costs for administration were substantially reduced as the Division of Health Care services absorbed the major administrative costs as part of their budget including, rent, utilities, administrative support, human resources, and I.T. support. Spending in direct services decreased from expected budgeted levels as clinics were reorganized and smaller communities where very few patients attended were absorbed into larger hub communities to gain greater efficiency and reduce the cost of services. In addition, the elimination of an expensive clinic for cardiology went into effect in FY05 as the private sector has adequate resources and infrastructure to serve the southeast part of the state. These changes resulted in a shift of funding to infrastructure building and population-based services. //2007//

/2009/ Spending in FY07 was less than budgeted due to programmatic changes that occurred with the EPSDT program and the use of state general fund dollars for outreach and meeting the intent of the Title V legislation regarding EPSDT. This change specifically affected spending particularly in the areas of pregnant women, infants less than 1 year and children 1-22 years of age. MCH Block grant funds continue to provide a significant base of support for these populations with half of all dollars spent collectively designated for infrastructure services. Administrative costs were close to budget and reflected costs associated with moving into a new location //2009//.

/2010/Spending in FFY2008 was more than budgeted as a result of additional funds received for MCH programs located in other divisions including behavioral health and the Women's, Infant and Children's Nutrition program. Additional medical funding was received in the Title V program to support school age children and for data analysis conducted by the MCH epidemiological staff for the Medicaid program. Additional funding from the Mental Health Trust Authority was received in support expansion of the autism diagnostic clinic and training for additional care providers to administer intensive

intervention services for children diagnosed with autism//2010//

B. Budget

/2006/ Form 2 outlines our proposed budget for the coming federal fiscal year. For Fy06, children's preventative and primary care comprise a minimum of 30% of the anticipated federal allocation. CSHCN reflects 33% of the federal allocation and includes expenditures for spending in the areas of direct services for pediatric specialty clinics to increase access to services and parent navigation (family care coordination). Administrative expenditures are budget to be no more than the allotted 10% of the budget.

Of note is that support from federal dollars has become the primary base of support and acts as either secondary or primary dollars for infrastructure or population-building services. The amount of general fund support has markedly decreased overtime and has been supplanted by Medicaid dollars in some cases or support has been eliminated altogether as outlined in the report on expenditures.

Budget priorities for FFY06 are focused on the new state performance measures identified as part of the 5 year Title V needs assessment and the national performance measures. This will include adding a new position to focus on perinatal and neonatal issues in support of primary and preventive care in the perinatal period. The current Title V/CSHCN director was originally hired to develop this program, but due to changes in structure and priorities over the last couple of years, roles have changed and it is not possible to add this to the work load of the director position. In addition, with the loss of federal and state general funds for the mandated morbidity and mortality review committee and the Alaska birth defects registry, the MCH Title V block grant will be covering the costs of these very important programs. Finally, dollars from the Title V block grant will be distributed to other divisions and sections that support some of the MCH priorities //2006//

/2007/ Form 2 outlines our proposed budget for the coming federal fiscal year. For FY07, children's preventative and primary care comprise a minimum of 33% of the anticipated federal allocation. CSHCN reflects 33% of the federal allocation and includes expenditures for spending in the areas of direct services for pediatric specialty clinics to increase access to services and parent navigation (family care coordination). Administrative expenditures are budget to be no more than the allotted 10% of the budget

Federal and State efforts:
The State of Alaska MCH Title V program utilizes both Title V funds and state dollars in support of pregnant women, infants less than 1, and children/adolescents (ages 1 to 22 years). Programs that benefits the population of Children with Special health care needs and thus meet the Title V requirement of over 30% included the Genetics, Birth Defects and Metabolic program, the pediatric specialty clinics including neurodevelopmental, spina bifida and cerebral palsy clinic, neurology clinic and the cleft lip and palate clinic. These clinics are offered in 6-8 communities across the state throughout the year in order to meet many of the national performance measures for CSHCN (organization of services for CSHCN, etc…). Title V funds are also used in combination with other federal grants to offer parent navigation services to families with a special needs child in an effort to navigate resources and payment options and achieve optimal program support of their child. These services have been primarily funded with the support of Title V dollars in the last couple of years with some support of Medicaid funding for travel of clients to rural hub communities or urban locations. With the re-organization of the maternal child health programs a second time beginning with SFY 06, funding will be available from receipts collected at some of the clinics and Medicaid fees billed for others again to support the clinics. Because the clinic administration and contracts were moved to the Division of Health Care services from SFY03 through SFY05, billed receipts were absorbed by the Division overall. Finally, Title V funds support the FAS and Birth Defects registry and surveillance program

Funding for preventative and primary care of children through outreach services for the EPSDT program, contraceptive services and supplies for adolescent through public health nursing centers, immunization education support, additional funding support for the Early Childhood and Care System Grant (ECCS), child abuse prevention efforts, domestic violence prevention, injury prevention efforts, maternal child surveillance including supporting the maternal morbidity and mortality surveillance committee, Pregnancy Risk Assessment and Monitoring program, a new Toddlers survey program.

Support for pregnant women and infants less than a year of age by Title V MCH Block grant provides supportive funding for programs such as the newborn metabolic screening, Back to Sleep prevention campaign, education regarding alcohol use and FAS, and SIDS and co-sleeping, MCH surveillance and epidemiology efforts, postpartum depression screening and education, smoking cessation efforts for pregnant women and preterm delivery and low birth weight prevention supports and child abuse prevention through intensive home visitation. Additional work will be forthcoming as a new perinatal nurse consultant position is hired supported by Title V funds.

A match in funds comes from a variety of sources including the state general fund match for Medicaid services for children and pregnant women, state funds for Early intervention, Women, Infant and Child nutrition program, and Team nutrition grants. In addition, there are state funds for child abuse prevention, fetal alcohol spectrum prevention, and pregnancy prevention.

Other federal grants are braided together with the Title V program to enhance program impact. These include CDC grants for the Pregnancy Risk Assessment Monitoring Program (PRAMS), Oral Health, Early Hearing, Detection and Intervention program (EHDI), and the Breast and Cervical Cancer Health Check program. Federal grants from HRSA include, SSDI, Abstinence Education, Oral Health, Universal Newborn Hearing Screening, Title X and a portion of Western States Genetics Collaborative.

Finally, with the reorganization of the most of the MCH programs back into the Division of Public Health, collection of fees and billing of Medicaid can resume which will provide for approximately an additional 100,000 in funding in SFY06 and 07. //2007//

/2009/ The budget for FFY2009 is anticipated to be similar to that submitted for FY08 with reductions in expenditures for pregnant women and children ages newborn to 22 years. Programs have been combined and streamlined since the re-emergence of the MCH program to provide for greater flexibility and cross trained staff. Staff has been been supportive of managing more than program and appreciate the exposure to programs and the training that comes with this exposure. In addition, less direct services are being offered than had been in the past. Training to health care providers and linkages with FQHC's and 330 clinics are ongoing to take advantage of the programs they offer and their requirements for case management and their focus on prevention and health promotion. The Title V program consistently looks for ways to braid and blend funding for new and existing programs to assure an ongoing plan for sustainability. A new position of School Health Nurse consultant will come on board in SFY09. This position will provide technical assistance to school districts around the state and those who have school nurses, provide information on standards of care and disaster planning. In addition, the position will be a liaison for the EPSDT program located in the Division of Health Care Services. //2009//

/2010/ The budget for FFY2010 is anticipated to be slightly increased as a result of an increase in general funds from the state in support of additional autism activities and financial support of the Alaska birth defects and FASD surveillance systems. This later program is a statutorily required program which has relied exclusively on MCH Title V Block grant funding for the last 5 years. Receipt of general funds dollars will assist in shifting block grant funding to support programs for school health, school nursing and

outreach of EPSDT screening. Additional expenditures are budgeted for CYSHCN in support of transition to adulthood and expansion of specialty clinics for screening of autism and neurodevelopmental disorders to 7 additional communities. The Title V program consistently looks for ways to braid and blend funding for new and existing programs to assure an ongoing plan for sustainability. A slight increase in federal funding for the Title V program is expected due to new and supplemental grants applied for in the areas of newborn hearing screening, asthma surveillance, and post partum depression.//2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.